APPENDIX M

EUTF REFERENCE GUIDES

Active Employee

Health Benefit Brochure

Supplement to 2005 Reference Guide for Active Employees

Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2006

INTRODUCTION

This benefits brochure supplements the 2005 Reference Guide for Active employees. The brochure only includes changes, additions and deletions to current health benefit plans. In addition, it provides an update of the changes to procedures or re-emphasizes key instructions to which each employee must comply. This brochure will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits or want another copy of the 2005 reference guide. For a more detailed explanation of your benefits, please contact the appropriate insurance carrier.

2006 OPEN ENROLLMENT

The open enrollment period is April 17 through May 19, 2006. Each active employee is receiving this brochure along with a pre-completed Open Enrollment Form for Active Employees (OE-1) that contains the information that EUTF had available as of March 1, 2006. If you have made or submitted any changes since February 1, 2006, your changes may not be reflected on the OE-1 enrollment form. You may contact the EUTF to verify any changes submitted after that date. Each employee is asked to review the information for accuracy of information and make any changes that are needed. You may cross out any information that should be deleted and legibly print any new information.

If you have no changes, you are done with open enrollment. You will be re-enrolled in the same plans and coverage that you currently have. If you have changes, additions or deletions, please submit your changes to your employer by May 19, 2006. Please ensure that you sign the OE-1 form.

OPEN ENROLLMENT ASSISTANCE

An Open Enrollment informational session schedule is included in this brochure. Any changes will be posted on our website, **www.eutf.hawaii.gov**. Please check the website for the most current schedule.

These meetings are offered so that you can meet with your insurance carriers to learn more about your EUTF benefit plans. The meetings will begin with a half-hour overview of the benefits. The remaining hour and a half is for you to meet with the insurance carriers and the EUTF staff. If you have questions regarding your pre-completed open enrollment form, please bring it with you to the open enrollment sessions listed below.

Special Announcement

IF YOU ARE A MEMBER OF BARGAINING UNIT 05, YOU NEED TO CONTACT YOUR UNION TO ENSURE THAT YOU ARE CORRECTLY ENROLLED IN BU05. Act 245, SLH 2005 allowed each employee organization to establish its own VEBA trust fund to handle its members. The only reason for you to receive an OE-1 and this brochure is because our records show and DOE confirmed that you are not a BU05 member. Effective March 1, 2006, all members of Bargaining Unit 05 and 45 are required to be administered by HSTA MBC for health benefits. If you retire on or after March 1, 2006, you will also be enrolled with HSTA MBC, not with the EUTF retiree plan. For more information contact: HSTA-Member Benefits Corporation, 1350 S. King St., Suite 230, Honolulu, HI 96814, Phone 808-591-2823, Fax 808-591-2652.

What do I have to do to ensure that my health benefits continue?

1. You should have received a pre-completed enrollment form (OE-2) that indicates the plans in which you are currently enrolled. Review this form to ensure that the plans noted are the plans you want. If the plan is incorrect or you want to change your plan or coverage, make the changes on the form. Please ensure that any changes you make are legible. Sign the form and return it to the EUTF no later than May 19, 2006.

2. If you have no changes, you are done with open enrollment. You will be reenrolled in the same plans and coverage that you currently have.

3. **IF YOU HAVE ANY CHANGES, IT IS ABSOLUTELY CRITICAL THAT YOU SUBMIT YOUR CHANGES TO YOUR PERSONNEL OFFICE NO LATER THAN MAY 19, 2006.**

4. When changes are made, the EUTF will send a confirmation notice to you. The confirmation notice allows you to ensure that the changes you submitted are correct.

Plan Benefit Changes and Clarifications

The health benefit plans for the period July 1, 2006 – June 30, 2007 will not change from the current plan year with the exception of Kaiser Permanente medical plan and the Aetna life insurance. A summary of the Kaiser Permanent medical plan changes and a revised life insurance amounts are shown below. Please refer to the 2005 Reference Guide for Active Employees or contact your insurance carrier to obtain an updated benefit brochure.

Long Term Care Insurance. The Long-Term Care plan, previously offered by Hartford Life Insurance, is no longer offered by the EUTF. However, those individuals that are currently covered under the plan will continue to be covered and will continue to be billed for the premium. Your coverage has not been cancelled. You coverage will continue for as long as you pay your premiums. Be advised that the insurance company has the right to increase your premiums after January 1, 2006. However, your premiums will be increased only if they are increased for all people covered by the plan.

MEDICAL AND PRESCRIPTION DRUGS PLAN

HMSA Medical and Prescription Drugs plan

Health benefits for all active employees remain the same. HMSA periodically reviews your health plans to ensure that these health plans provide you with quality health plan benefits in compliance with state and federal laws and are structured to best manage health care costs.

This document is for general information use only and is not for use as the certificate for the plan. The *Guide to Benefits* will contain complete information on these changes as well as, other benefits and applicable exclusions and limitations of your plan. In the case of a discrepancy between this summary and the language contained in the *Guide to Benefits* or plan certificate, the *Guide to Benefits* or plan certificate take precedence. You can find this Guide to Benefits at the HMSA website for EUTF at www.hmsa.com/portal/ and or you may access this website through the EUTF website, www.eutf.hawaii.gov by clicking on the "Links to Carrier" line. HMSA has created a special site for EUTF members.

The changes made were either administrative or language clarifications in nature and applies to the HMSA PPO, HMSA Dual and the HMSA Prescription Drugs plans, as appropriate. The most significant administrative changes dealt with precertification requirements for some services to reflect the current policies. For a complete listing of these changes, please contact your local HMSA officer or visit the HMSA website noted above.

KAISER PERMANENTE Medical Plan

This is only a summary of the Kaiser Permanente plan changes which are effective July 1, 2006. It does not fully describe your benefit coverage. Details on the exact terms of your benefit coverage, exclusions, and plan terms are in a Service Agreement between the EUTF and Kaiser Permanente. The Service Agreement is the binding contractual document between Kaiser, the EUTF, and EUTF Kaiser members. For details of your benefit coverage, exclusions, and plan terms or to obtain a packet of benefit information, please contact the Kaiser Customer Service Center at (808) 432-5955 (Oahu) or toll-free, 1-800-966-5955 (Neighbor Islands) or log on to my.kaiserpermanente.org/hi/eutf.

Summary of 2006 Important Changes

Benefit and contract changes:
1. **Office visit copayment.** Increase from $12 to $14 per visit.
2. Inpatient/Outpatient lab, imaging, and testing. Currently no charge, changed to a 10% copay for these services.
3. Preventive screening services. Certain preventive screening services will not be subject to the 10% copay and instead be covered at no charge. Office visit copay will be charged if applicable. The list of services that fall under the preventive screening benefit is in the Service Agreement.

4. Physical, occupational, and speech therapy. There will no longer be a 2 month limit on these therapies. However, keep in mind that only short term therapy is covered. As determined by a Kaiser Permanente physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.
5. Serious mental illness parity. The serious mental illness (parity) benefit has been expanded to include obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression.
6. Live or work. Subscribers must live or work in the Hawaii service area to be enrolled in a Kaiser Permanente plan. Family dependents must live in the Hawaii service area to enroll (or continue to be enrolled) in a Kaiser Permanente plan.
Benefit and contract clarifications:
1. Office visits. An office visit is defined as evaluation and management services, which may include some or all of the following: examination, history, and/or medical decision making. Office visits do not include, for example, outpatient procedures. Outpatient procedures would be covered per the member's outpatient procedures benefit.
2. Physical, occupational, and speech therapy. Physical, occupational, and speech therapy deficits due to developmental delay are not covered.
3. Family dependent child. The definition of "child" for purposes of enrolling as a family dependent is defined in the EUTF Administrative Rules.

For exact details on your benefit coverage, exclusions, and plan terms, please refer to EUTF's Service Agreement that includes applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders. This Service Agreement is the legal binding document between Health Plan and its members. Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

NOTE: General reminder for all members:
Unless explicitly described in a particular benefit section, each medical service or item is covered according to its relevant benefit section. For example, labs or blood related to a hospital stay are not covered under the hospital benefit. Labs related to a hospital stay are covered under the lab benefit. Blood received during a hospital stay is covered under the blood benefit.
Kaiser Permanente's web services now allow you to make appointments, order prescription refills, and more. For more information log on to my.kaiserpermanente.org/hi/eutf or contact the Customer Service Center at (808) 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Royal State Dual Medical Plan – no benefit changes

CHIROPRACTIC

ChiroPlan Hawaii by MBAH – no benefit changes

DENTAL

HDS Regular and HDS Dual plans

Your HDS benefits remain the same. The EUTF Reference Guide for Active Employees published in 2005 did not indicate the coverage for implants. Implants are covered at 60%, limited to the plan maximum (as an alternate benefit), when one tooth is missing between two natural teeth.

HDS recently launched a phone service, as another resource, called HDS DenTel. You may call HDS DenTel to find out when you are eligible for your next dental visit, obtain claims information, or even have a summary of your plan benefits faxed or mailed to you, simply by following the prompts on the phone. The number is (808) 529-9333 or toll free from the Neighbor Islands or the Continental USA at 1-800-232-2533, ext. 333.

The HDS Customer Service Department is also available at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248.

For a full description of your dental benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov. You may also obtain information from the HDS website, www.deltadentalhi.org. Certain limitations, restrictions and exclusions may apply to the plan. In the case of a discrepancy the HDS Schedule of Benefits will govern.

VISION

VSP Regular and VSP Dual plans

Your vision benefits for both plans remain the same.

AETNA Life Insurance

Life insurance benefits, underwritten by Aetna Life Insurance Company, were increased by approximately 20% over the previous year's ceilings at no additional cost to the employer or the employee. For complete information and provisions, contact Aetna Customer Service at 1-866-227-9954 or visit their website, www.aetna.com.

Submit claims to: Aetna Inc. Life Service Center
151 Farmington Avenue – RE52
Hartford, CT 06156-3007
Fax Number for Claim Submission: 1-800-238-6239

In the event of your death, the life insurance company will pay your beneficiary the applicable amount of life insurance benefits as shown below:

Classification	Benefit Amount
Under age 65	$31,217
Age 65 through 69	$20,291
Age 70 through 74	$14,048
Age 75 through 79	$9,365
Age 80 and over	$6,243

Open Enrollment Informational Sessions Schedule

The EUTF has scheduled several Open Enrollment Informational sessions for your convenience. These sessions will be your opportunity to obtain more information regarding your health benefits. The health plans will have representatives to field any of your questions or concerns.

Date	Time	Location
04/20/06	9:00 a.m.	Leeward Community College, GT105
04/20/06	11:00 a.m.	Leeward Community College, GT105
04/20/06	2:00 p.m.	Leeward Community College, GT105
04/21/06	1:00 p.m.	Kona Armory
05/01/06	11:00 a.m.	Waikapu Comm. Center
05/01/06	2:00 p.m.	Waikapu Comm. Center
05/03/06	8:30 a.m.	Hemenway Theatre
05/03/06	11:00 a.m.	Hemenway Theatre
05/04/06	9:00 a.m.	Windward Comm. College
05/04/06	11:00 a.m.	Windward Comm. College
05/04/06	2:00 p.m.	Windward Comm. College
05/08/06	11:00 a.m.	Kauai War Memorial Convention Center
05/08/06	2:00 p.m.	Kauai War Memorial Convention Center
05/09/06	9:00 a.m.	Capitol Auditorium
05/09/06	11:00 a.m.	Capitol Auditorium
05/09/06	2:00 p.m.	Capitol Auditorium
05/11/06	9:00 a.m.	Aunt Sally Kaleohano's Luau Hale
05/11/06	1:00 p.m.	Aunt Sally Kaleohano's Luau Hale
05/16/06	9:00 a.m.	Kahala Community & Recreation Center
05/16/06	1:00 p.m.	Kahala Community & Recreation Center
05/17/06	9:00 a.m.	Kapolei Hale, Conference Room A
05/17/06	11:00 a.m.	Kapolei Hale, Conference Room A
05/17/06	2:00 p.m.	Kapolei Hale, Conference Room A
05/18/06	9:00 a.m.	City Hall Annex, Mission Memorial Aud.
05/18/06	11:00 a.m.	City Hall Annex, Mission Memorial Aud
05/18/06	2:00 p.m.	City Hall Annex, Mission Memorial Aud

Open Enrollment Locations

OAHU

Leeward Community College, GT105
96-045 Ala Ike
Pearl City, HI 96782

Kapolei Hale Conference Room A
1000 Uluohia Street
Kapolei, HI 96707

Kahala Community Center
4495 Pahoa Avenue
Honolulu, HI 96822

U.H. Hemenway Theatre
2445 Campus Road
Honolulu, HI 96822

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

Windward Community College, Akoakoa Room
45-720 Keaahala Road
Kaneohe, HI 96744

City Hall Annex, Mission Memorial Auditorium
550 S Beretania St
Honolulu, HI 96813

HAWAII

Kona Armory
81-1032 Nani Kupuna Rd.
Kealakekua, HI 96740

Aunt Sally Kaleohano's Luau Hale
799 Piilani Street
Hilo, HI 96720

MAUI

Waikapu Community Center
22 E. Waiko Rd.
Wailuku, HI 96793

KAUAI

Kauai War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

Premium Rates for Plans Effective July 1, 2006

Carrier	Type of Plan	Coverage	Employer Contribution	Employee Contribution	Total Premiums
HMSA	PPO Medical, Drugs, Chiropractic	Single	$155.42	**$102.48**	$257.90
		Family	$467.84	**$308.54**	$776.38
Kaiser	HMO Medical, Drugs, Chiropractic	Single	$155.42	**$112.70**	$268.12
		Family	$467.84	**$335.30**	$803.14
HMSA	Dual Medical, Drugs, Chiropractic	Single	$87.28	**$57.06**	$144.34
		Family	$265.46	**$173.60**	$439.06
Royal State	Dual Medical, Drugs, Chiropractic	Single	$26.50	**$16.54**	$43.04
		Family	$81.74	**$51.12**	$132.86
HMSA	Prescription Drugs Only	Single	$29.88	**$19.62**	$49.50
		Family	$91.92	**$60.38**	$152.30
HDS	Dental	Single	$17.38	**$11.48**	$28.86
		Family	$59.50	**$22.94**	$82.44
HDS	Dual Dental	Single	$10.30	**$6.76**	$17.06
		Family	$29.76	**$19.52**	$49.28
VSP	Vision	Single	$3.44	**$2.28**	$5.72
		Family	$7.40	**$4.88**	$12.28
VSP	Dual Vision	Single	$1.54	**$1.02**	$2.56
		Family	$3.36	**$2.18**	$5.54
AETNA	Life Insurance	Employee	$4.16	**None**	$4.16

To Contact the EUTF:

Mailing Address: P.O. Box 2121, Honolulu HI 96805

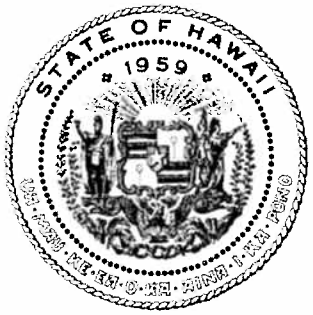
Location Address: 201 Merchant Street, Suite 1520, City Fiinancial Tower, Honolulu, Hawaii

Telephone Numbers

Local number: 808-586-7390 Toll-Free number: 800-295-0089

Fax number: 808-586-2161

Email address: eutf@hawaii.gov Website address: www.eutf.hawaii.gov



Reference Guide For Active Employees

Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2005

REPRINTED MARCH 2006

Reference Guide for Active Employees

Table of Contents

INTRODUCTION

This benefits booklet is designed to help public employees understand the benefit options available to them and assist public employees in enrolling or changing their enrollment in the benefit plans offered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). This booklet will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits.

2005 OPEN ENROLLMENT IS EASY!

The open enrollment period is April 18 through May 20, 2005. Each active employee should have received a pre-completed Open Enrollment Form for Active Employees (OE-1) that contains the information that EUTF had available as of the beginning of March 2005. Each employee is asked to review the information for accuracy of information and make any changes that are needed. You may cross out any information that should be deleted and print legibly any new information.

If you have no changes, you are done with open enrollment. You will be re-enrolled in the same plans and coverage that you currently have. Otherwise, return the changed and signed OE-1 by May 20, 2005 to your personnel office.

Rates

At the time this reference guide went to press, collective bargaining was not complete. When collective bargaining is complete you will be informed of the employee contribution required for each plan.

Plan Benefit Changes

HDS dental coverage will now include pulp vitality testing for emergency situations, as well as guided tissue regeneration, bone replacement grafts and soft tissue allografts for advanced periodontal disease. Titanium crowns, pontics, inlays and onlays, prefabricated steel crowns and procedures to construct new crowns under existing partial dentures are also now included. Age limits have also increased for some services, as shown in the benefit summary in this booklet.

Kaiser Permanente coverage is available to all Hawaii residents except for a few living on the southern tip of the island of Hawaii in zip codes 96718, 96772 and 96777. .

The plan now has an increased copayment of $12 rather than $10, is now offering some preventive screening services without a lab/x-ray copayment, and has changed the copayment structure for contraceptive drugs and devices to 50% of costs, rather than $10 per 30-day supply.

In addition, billing charges for Kaiser services not paid on the date of service will increase to $20 from $15, and any outstanding balances over 60 days will be subject to a 12% simple interest charge.

Inpatient and outpatient chemical dependency benefits will be provided in accordance with state law, in which copayments and limits are the same as for any other physical disease or illness.

Long Term Care Insurance. The Long-Term Care plan, currently offered by Hartford Life Insurance, will no longer be offered to new applicants. **T**hose individuals that are currently covered under the plan will continue to be covered and will continue to be billed for the premium. Your coverage is not being cancelled. The insurance company has the right to increase your premiums after January 1, 2006. They can only increase premiums if they are increased for all people covered by the plan.

OPEN ENROLLMENT ASSISTANCE

The EUTF will be contacting you to invite you to attend Open Enrollment informational sessions. **Please check our website, www.eutf.hawaii.gov, for the most current schedule.**

These meetings are offered so that you can meet with your insurance carriers to learn more about your EUTF benefit plans. The meetings will begin with a half-hour overview of the benefits. The remaining hour and a half is for you to meet with the insurance carriers and the EUTF staff. If you have questions regarding your pre-completed open enrollment form, please bring it with you.

Please note: Because there are minimal changes to the plans in 2005, the EUTF has not requested paid time off for employees to attend these meetings.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet
- Paying the employee's premium contributions in the amount or amounts provided by statute, an

applicable bargaining unit agreement, or by the applicable EUTF benefit plan;

- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the EUTF's rules.

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the Hawaii Revised Statutes;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries; and
- Complying with the EUTF's rules.

Enforcement Actions of the EUTF

Verifications

The EUTF may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in the EUTF's Administrative Rules. The Administrative Rules are available at the EUTF website, www.eutf.hawaii.gov.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the EUTF and all coverage for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c).

Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the EUTF's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

The EUTF shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the EUTF.

Active Employee Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF. Enrollments, terminations, and other changes must be presented through your employer to the EUTF. If you have any questions concerning eligibility provisions, you should check with your personnel office, call the EUTF Customer Service at 808-586-7390 or reference the Administrative Rules posted on the EUTF website, www.eutf.hawaii.gov.

Health Plans

Employee-beneficiaries. The following persons shall be eligible to enroll as employee beneficiaries in the benefit plans offered or sponsored by the EUTF:

- An employee, including an elective officer of the State, county or legislature
- A retired employee
- Surviving spouse of an employee killed in performance of duty, spouse does not remarry
- Surviving spouse of a retired employee, spouse does not remarry
- Unmarried child of an employee killed in performance of duty providing child is under age 19 and has no surviving parent
- Unmarried child of retiree and under age 19 with no surviving parent

Please note: Surviving spouse coverage does not extend to domestic partners.

Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF:

- Spouse or domestic partner (DP)
- Unmarried children under age 19 or full-time student under the age of 24
- Unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19
- Child covered by terms of a qualified medical child support order (QMCSO).

Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the EUTF, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

Special Eligibility Requirements

Student

A child over age 19 and under 24 is eligible if attending a full-time accredited college, university or technical school. This includes children who are away at school and dependent upon you for support.

Domestic Partner

Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely
2. Have a common residence and intend to reside together indefinitely
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care
4. Neither are married or a member of another domestic partnership
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii
6. Both at least 18 years of age and mentally competent to contract
7. Consent to the domestic partnership not been obtained by force, duress or fraud
8. Both sign and file a declaration of domestic partnership (affidavit) to the EUTF

If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on your W-2. This income is subject to normal payroll taxes. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available on the EUTF website, www.eutf.hawaii.gov) to the EUTF. Please refer to the website for detailed information and instructions.

Enrollment

During Open Enrollment 2005, **you need only return your pre-completed OE-1 form if you are making changes**. Subsequently, those who become eligible must complete an EUTF Enrollment Form for Active Employees (EC-1).

If you do not enroll all eligible members of your family within 30 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year, usually two to three months prior to July 1. Coverage dates for all plans begin July 1 and end June 30 of the following year.

ID Cards

After you enroll for the first time, you will receive identification cards from the plans as follows:

- HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- Kaiser issues an ID card for each enrolled member of a family upon initial enrollment.
- VSP, Mutual Benefit Association of Hawaii (provider of ChiroPlan) and Royal State do not issue ID cards.

If you do not change any of your elections, you may not receive new ID cards.

Dual Enrollment Is Not Allowed

Dual enrollment is not allowed under the EUTF rules. If both you and your spouse are employees of the State or a county, only one of you may enroll in a Family plan, or if no other dependents are involved, both of you may enroll in a Self plan. If your spouse has coverage outside of the EUTF that provides a family coverage, this rule does not preclude you from

also enrolling in a family coverage plan to cover your spouse. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Reimbursement

Anyone enrolled in an active employee medical plan that is also enrolled in Medicare Part B does not receive reimbursement from the EUTF for their premiums. Only retirees and their spouses, who are enrolled in an EUTF retiree medical plan, are eligible for the Part B reimbursement. If you are an active employee and enrolled in Medicare Part B but covered by the EUTF retiree plan through your spouse, your spouse is entitled to Medicare Part B reimbursement for you. Domestic partners of retirees are not eligible for Part B reimbursement.

Change of Coverage

To change your coverage, you should contact your personnel officer and complete an EC-1 form. You are eligible to change your coverage outside the Open Enrollment period only under the following circumstances:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide court documents verifying the adoption in order to have the application accepted.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., separation, divorce, death, child marries, no longer lives with you, or turns age 19 or 24 for student).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

Effective Dates of Coverage

For new hires, the effective date of coverage is the first day of work. There is no waiting period following your date of hire before your health benefits coverage begins, provided you submit a completed EC-1 to your employer within 30 days of your hire date. Your enrolled eligible dependents' coverage is effective the same date as yours.

Although **your coverage begins immediately**, payroll deductions for your premiums are not assessed sooner than the first day of the second pay period after your hire date. Regardless of when your payroll deductions begin, if you need to obtain services from any of the carriers, **you do not need to wait until you receive your ID cards**. The EUTF can arrange for you to receive them or you can ask your provider to delay submitting the claim for payment until your application has been processed and the carrier has recorded your enrollment. If your payroll deductions do not begin with your second pay period, they will be retroactive to your second pay period when they do begin.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately - so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event or the date the EUTF receives proper notification, depending on the event and providing that the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24, in the case of full-time students, and do not require the completion of an application to delete coverage. If your student graduates or drops out of school before age 24, your student becomes ineligible and you must submit an EC-1 to remove the student from coverage.

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.
If you transfer employment within 90 calendar days of the last day of employment with the previous employer, you will not be subject to sections 87A-35 and 87A-36, Hawaii Revised Statutes. These paragraphs define the manner in which an employee's years of service are to be computed to determine the employer contributions for retiree benefits.

End of Coverage

Coverage for you and your dependents will end if:

1. You voluntarily terminate coverage.
2. Your employment terminates.
3. Your hours are reduced so you no longer qualify for coverage.
4. You do not make required premium payments.
5. You die except for certain exceptions.
6. Your employer ceases to participate in the EUTF.
7. The EUTF is discontinued.

Coverage for your dependents will end if:

1. Your dependent is no longer eligible for coverage.

2. Your enrolled dependent enters the uniformed services.

Effective Date of Termination

In general, coverage ends on the first day of the pay period after the event giving rise to the end of coverage. There may be certain instances in which the effective date is different such as a divorce, when coverage ends on the date the EUTF receives notification of the divorce. You may obtain additional information from your DPO or by referring to the EUTF Administrative Rules that are posted on the EUTF website, www.eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria outlined on the previous pages and detailed in the Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;

2. The application is not filed within the time limitations prescribed by the rules;

3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;

4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or

5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified of the rejection of any enrollment application.

Administrative Appeals

A person aggrieved by one of the following decisions by the EUTF may appeal to the board for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;

2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;

3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or

4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;

2. A description of the decision with respect to which relief is requested, including the date of the decision;

3. A statement of the relevant and material facts; and

4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;

2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;

3. A description of the decision with respect to which relief is requested, including, the date of the decision;

4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The board shall grant or deny the appeal within a reasonable amount of time. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the EUTF's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

State of Hawaii Employees Only

By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.

2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.

3. Allowable changes/cancellations will generally take effect the month after you file, so to avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 form; never retroactively.

4. Your election, in the absence of an allowable change in status, cannot be changed for the current plan year.

5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP authorization will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

Enrollment Form Instructions

A. Print or type clearly, if form is unreadable it may be sent back to you.
B. **Please submit form to your Personnel Office or Department Personnel Officer (DPO) for verification.**
C. Sections:

1. Event – DPO, please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Termination, Transfer In, Transfer Out, Address Chg, Marital Status Chg, Retire, Rehire, New Hire, Death, Student, Add Dep, Cancel etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a "birth" and an "address change", enter "Birth" in the event section.
2. Event Date – DPO, please enter the date the event took place or July 1 for Open Enrollment..
3. Enter Employee's information for: Last Name, First Name, M.I., Social Security No., Mailing Address, City, State, Zip Code, Marital Status, Gender, Birth Date and Daytime/Evening Phone Number in the appropriate spaces.
4. Enter Social Security Number of Spouse or Domestic Partner and check appropriate box.
5. Check add box to add dependent, check delete box to delete dependent.
6. Enter Employee's Dependent(s) Name, Birth date, and SSN.
   If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
7. Use the following codes for Relationship column:
   SP = Spouse **CH** = Child **DC** = Disabled Child√√
   DP = Domestic Partner√ **DPC** = Domestic Partner Child√
   For Relationship codes with √ or √√, please see item #17 below for other required forms.
8. Gender – circle either M or F.
9. Plan Selections (See Reference Guide for Plan Coverage Details). For Dual Medical plan coverage details see your personnel office or visit the EUTF website. Select only 1 box from each Plan Section.

If you are selecting Medical Dual, Vision Dual or Dental Dual, you must have other coverage from another source outside of EUTF.

10. PCP – this section is for State employees only. Select Enroll, Do Not Enroll, Change amount, or Cancel. PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form. (See the Reference Guide for Active Employees for details on PCP).
11. Comments – use this section for your comments
12. **Certification**
    Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee authorizes their employer or finance officer to set the effective dates of coverage and to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.
    Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Employee affirms that they have non-EUTF plan benefits for each Dual Coverage Plan selected. Employee signature also affirms that they have read and understood the PCP section in the Reference Guide for Active Employees.
    Please enter date of Employee's signature.
13. DPO signature certifies applicant is eligible as defined in Section 87A, HRS. Enter date you received EC1 from your employee.
    DPO – Please provide your phone and fax numbers.
14. Department ID code – DPO, please enter your appropriate Department ID code. For example, 010021 for Department of Education, 010022 for University of Hawaii, 040028 for City and County of Honolulu Emergency Services, etc.
15. Dept: and Division/School: - Optional fields for DPO use only.
16. Bargaining Unit number – DPO, please enter the appropriate bargaining unit for this employee.
17. Other EUTF forms to include with EC-1 (if applicable):
    √Domestic Partnership Declaration or Termination
    √Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
    √Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
    √√D-1 (5/2003) for enrolling disabled child

AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)

Keep a copy for your reference

EC-1

Hawaii Employer-Union Health Benefits Trust Fund
ENROLLMENT FORM FOR ACTIVE EMPLOYEES

1. Event:

2. Event Date: (MM/DD/YY)

See Instructions on reverse side BEFORE completing this form. Refer to your reference guide or our website for plan details.

3a. Employee's Last Name, First, M.I.

3b. Social Security Number

3c. Mailing Address:

3g. Zip Code:

3h. Gender: ☐ Male ☐ Female

3i. Birth Date: (MM/DD/YY)

3j. Phone Number – Work

4. Social Security Number of Spouse or Domestic Partner

__ __ __ / __ __ / __ __ __ __

☐ State or County - Employee or Retiree

☐ Other – Private, Federal ,etc.

3k. Phone Number – Home

5a. Add	5b. Delete	6a. Dependents: First Name, M.I., Last Name (if different)	6b. Birth Date (MM/DD/YY)	6c. Social Security Number	7. Relationship	8. Gender
☐	☐					M F
☐	☐					M F
☐	☐					M F
☐	☐					M F
☐	☐					M F

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan Section	*Carrier Selection*	*Self*	*Family*	*Cancel/Waive*
Medical/Drug, Chiropractic (choose Self, Family or Cancel/Waive)	HMSA PPO Medical and Drug, MBAH ChiroPlan	☐	☐	☐
	Kaiser Medical and Drug, MBAH ChiroPlan	☐	☐	
	HMSA Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)	☐	☐	
	Royal State Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)	☐	☐	
	HMSA Prescription Drug Only (Cannot be combined with any plan listed above)	☐	☐	
Dental (choose Self, Family or Cancel/Waive)	HDS Dental	☐	☐	☐
	HDS Dual Coverage Dental (I have dental coverage from another source outside of EUTF)	☐	☐	
Vision (choose Self, Family or Cancel/Waive)	VSP Vision	☐	☐	☐
	VSP Dual Coverage Vision (I have vision coverage from another source outside of EUTF)	☐	☐	
AETNA Life Insurance Plan		☐		☐

10. **State Employees ONLY (Premium Conversion Plan)** ☐ Enroll ☐ Do NOT Enroll ☐ Change amount ☐ Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)

Employee Signature: _____ Date: _____

13. DPO Signature: _____ Date: _____ DPO Phone: _____ DPO FAX: _____

14. Dept. ID# __ __ __ __ __ __	15a. Dept:	15b. Division/ School:	16. Barg. Unit:

EC1

SUBMIT TO YOUR PERSONNEL OFFICE

Form EC-1 Revised July 2005

Medical - PPO Plan

HMSA

Blue Cross Blue Shield of Hawaii

This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained by calling HMSA or from the EUTF website, www.eutf.hawaii.gov, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits, the latter will take precedence.

If you have questions, please contact HMSA at any of the following locations:

Oah	818 Keeaumoku Street Honolulu, HI 96814 Phone: (808) 948-6499	Hawaii	670 Ponahawai Street, Suite Hilo, HI 96720 Phone: (808) 935-5441		75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 Phone: (808) 329-5291
Kauai	4366 Kukui grove Street, Suite 103 Lihue, HI 96766 Phone: (808) 245-3393	Maui	33 Lono Avenue, Suite 350 Kahului, HI 96732 Phone: (808) 871-6295		

All member copayments shown are based on the eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. Services received from a non-participating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

Lifetime Maximum	$2,000,000	
Maximum Annual Co-payment	$1,500 per person	$4,500 per family
Annual Deductible (nonparticipating providers only)	None	$100 per person/$300 per family
	Member Copayment	
	Participating Provider	**Nonparticipating Provider** Copayment amount after annual deductible met where noted (*)
Physician Services		
Physician Visits, Well Woman, Surgical Services, Maternity Care	10% of Eligible Charges	30% of Eligible Charges*
Well Child Care Exams—Limitations apply	None	30% of Eligible Charges
Immunizations including Hepatitis B	None	None
Testing, Laboratory and Radiology—Outpatient [1]		
Allergy Test, Diagnostic Test and Radiology, Tuberculin Skin Test, Pap Smear, PSA, RSVP Screening	10% of Eligible Charges	30% of Eligible Charges*
Screening Mammography	10% of Eligible Charges	30% of Eligible Charges

Note: [1] HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.

HMSA
Blue Cross Blue Shield

	Member Copayment	
	Participating Provider	**Nonparticipating Provider**
Organ and Tissue Transplants		
Corneal, Kindey, Small Bowel, Small Bowel/Liver Transplants	10% of Eligible Charges	30% of Eligible Charges*
Bone Marrow, Heart, Heart/Lung, Liver, Lung, Kidney/Pancreas Transplants or Transplant Evaluation[2]	None	Not Covered
Note: [2] HMSA has contracted with certain providers for specific transplant services. You must receive services from a contracted provider for this benefit to apply.		
Chemotherapy and Radiation Therapy--Outpatient		
Chemotherapy, Radiation Therapy	10% of Eligible Charges	30% of Eligible Charges*
Hospital and Facility Services		
Emergency Room	10% of Eligible Charges	10% of Eligible Charges
Hospital Room, Skilled Nursing Facility, Ambulatory Surgical Center	10% of Eligible Charges	30% of Eligible Charges*
Behavioral Health - Mental Health [3] and Substance Abuse		
Inpatient Hospital/Facility Services, Physician Services	Regular Plan Benefits	Regular Plan Benefits
Psychological Testing – Inpatient or Outpatient	10% of Eligible Charges	30% of Eligible Charges*
Note: [3] Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year. Limitations do not apply to serious mental illnesses in accord with Hawaii law. There is no limit for substance		
Special Benefits for Homebound, Terminal, or Long-term Care		
Home Health Care	None	30% of Eligible Charges*
Hospice Services	None	Not Covered
Other Medical Services and Supplies		
Ambulance, Appliances/Equipment, Blood, Dialysis, Injections, Physical Therapy, Occupational Therapy, or Speech Therapy	10% of Eligible Charges	30% of Eligible Charges*
Medical Foods	10% of Eligible Charges	20% of Eligible Charges
Special Benefits for Health Assessment, Health Education, and Disease Management		
HealthPass, Disease Management Programs, Health Appraisal [4]	None	Not Covered
Physical Exam [4]	Any amount exceeding HMSA's allowance of up to $41.50 ages 6 – 12 years $62 ages 13 – 18 years $113.50 ages 19 – 39 years $170.00 ages over 40 years	
Note: [4] Coverage includes benefits for either one Health Appraisal Program or one Physical Exam per calendar year.		

Medical - PPO Plan Prescription Benefits

Prescription Drug-Only Plan Benefits

HMSA

Blue Cross Blue Shield

BENEFITS	MEMBER PAYS	
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Preferred Brand Name	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Brand Name	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Insulin		
Preferred Insulin	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Insulin	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	$15 copayment	$15 copayment
Oral Contraceptives		
Preferred Oral Contraceptives	$5 copayment	$8 copayment
Other Oral Contraceptives (including generic contraceptives)	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diaphragms		
Preferred Diaphragms	$10 copayment	$12 copayment
Other Diaphragms	$20 copayment	$20 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	**HMSA Vendor**	**Non-HMSA Vendor**
Generic	$10 copayment	Not a benefit
Preferred Brand Name	$35 copayment	Not a benefit
Other Brand Name	$60 copayment	Not a benefit
Insulin		
Preferred Insulin	$10 copayment	Not a benefit
Other Insulin	$35 copayment	Not a benefit
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	Not a benefit
Other Diabetic Supplies	$35 copayment	Not a benefit

Medical - HMO Plan

KAISER PERMANENTE

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician. For specific questions about coverage, please call the Customer Service Center at (808) 432-5955 (Oahu) or 1-(800) 966-5955 (Neighbor Islands). You may also obtain information from the Kaiser website, www.kaiserpermanente.org.

Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

	Benefits	You pay
	Deductible	None
	Lifetime Maximum	None
	Annual supplemental charges maximum per calendar year	$1,500 per member
		$4,500 per family unit (3 or more members)
Preventive services	**Well-baby visits**	$12 office visit copayment per visit
	Immunizations	No charge for most immunizations (some have a 50% copayment)
	Physicals, routine and school	$12 office visit copayment per visit
Outpatient services	**Office visits,** doctors' & other health professionals'	$12 office visit copayment per visit
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Outpatient surgery and procedures	$12 office visit copayment per visit
	Routine obstetrical care (prenatal, delivery, and mother's care in the hospital following delivery)	No charge upon confirmation of pregnancy
	Abortions, elective or medically indicated	$12 per visit (elective abortions limited to two per lifetime)
	Administered drugs	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit charge for the visit.
	FDA-Approved contraceptive drugs and services	50% of applicable charges

Medical - HMO Plan Continued

KAISER PERMANENTE

	Benefits	You pay
Inpatient services	**Hospital (room and board**	No charge
	Doctors' medical and surgical services	No charge
	Anesthesia services	No charge
	Lab, X-ray, and diagnostic testing	No charge
	Administered drugs	No charge for most drugs administered during a covered hospital stay
	Skilled nursing care	No charge up to 100 days per benefit period
Mental health services (B rider	**Outpatient up to 24 visits/calendar year**	$12 office visit copayment per visit
	Inpatient up to 30 days/calendar year	No charge
Chemical dependenc y services	**Outpatient**	$12 office visit copayment per visit
	Inpatient	No charge
Emergency services (for initial treatment only) & ambulance services	**At a facility <u>within</u> the Hawaii service area**	$25 per visit, plus other applicable plan charges
	At a facility <u>outside</u> the Hawaii service area	20% of R & C*, plus other applicable plan charges
	Ambulance services	20% of R & C*, plus other applicable plan charges
Additional Services	**Prescription drugs – drug 10**	$10 for each prescription not exceeding a 30 consecutive day supply (excludes contraceptive drugs and devices)
	Prescription drug mail order incentive	Members may purchase mail order refills for most maintenance drugs for a 90 consecutive day supply upon payment of two drug copayments. The mail order program does not apply to certain drugs and mailing is limited to addresses inside the State of Hawaii.
Internal/ External prosthesis	**Durable medical equipment**	20% of applicable charges

You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.

Dual-Coverage Medical Benefits

Active Employees who have medical coverage through private sector or federal government plans have the option to select a dual-coverage medical plan as a supplement. Active employees have a choice between dual-coverage benefits offered by HMSA and the Royal State National Insurance Company Limited. Summaries of the benefits offered by each carrier follow.

HMSA Dual-Coverage Medical and Prescription Benefits

HMSA

This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained by calling HMSA or from the EUTF website, www.eutf.hawaii.gov, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits, the latter will take precedence.

If you have questions, please contact HMSA at any of the following locations:

Oahu	818 Keeaumoku Street Honolulu, HI 96814 Phone: (808) 948-6499	Hawaii	670 Ponahawai Street, Suite 121 Hilo, HI 96720 Phone: (808) 935-5441		75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 Phone: (808) 329-5291
Kauai	4366 Kukui grove Street, Suite 103 Lihue, HI 96766 Phone: (808) 245-3393	Maui	33 Lono Avenue, Suite 350 Kahului, HI 96732 Phone: (808) 871-6295		

All member copayments shown are based on the eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. Services received from a non-participating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

Lifetime Maximum	$1,000,000	
Maximum Annual Co-payment	$10,000 per person	
	Member Copayment	
	Participating Provider	**Nonparticipating Provider**
Physician Services		
Physician Visits, Surgical Services, Maternity Care	50% of Eligible Charges	50% of Eligible Charges
Well Woman, Well Child Care Exams—Limitations apply	None	50% of Eligible Charges
Immunizations (Standard)	50% of Eligible Charges	50% of Eligible Charges
Immunizations (Well Child Care)	None	None
Testing, Laboratory and Radiology—Outpatient [1]		
Allergy Test, Diagnostic Test and Radiology, Tuberculin Skin Test	50% of Eligible Charges	50% of Eligible Charges

HMSA Blue Cross Blue Shield

	Member Copayment	
	Participating Provider	**Nonparticipating Provider**
Screening Mammography, Pap Smear, PSA, RSVP Screening	None	50% of Eligible Charges

Note: [1] HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.

Organ and Tissue Transplants		
Corneal, Kidney, Small Bowel, Small Bowel/Liver Transplants	50% of Eligible Charges	50% of Eligible Charges
Bone Marrow, Heart, Heart/Lung, Liver, Lung, Kidney/Pancreas Transplants or Transplant Evaluation[2]	None	Not Covered

Note: [2] HMSA has contracted with certain providers for specific transplant services. You must receive services from a contracted provider for this benefit to apply.

Chemotherapy and Radiation Therapy--Outpatient		
Chemotherapy, Radiation Therapy	50% of Eligible Charges	50% of Eligible Charges
Hospital and Facility Services		
Emergency Room	50% of Eligible Charges	50% of Eligible Charges
Hospital Room, Skilled Nursing Facility, Ambulatory Surgical Center	50% of Eligible Charges	50% of Eligible Charges
Behavioral Health - Mental Health [3] and Substance Abuse		
Inpatient Hospital/Facility Services, Physician Services	Regular Plan Benefits	Regular Plan Benefits
Psychological Testing – Inpatient or Outpatient	50% of Eligible Charges	50% of Eligible Charges

Note: [3] Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year. Limitations do not apply to serious mental illnesses in accord with Hawaii law. There is no limit for substance abuse services.

Special Benefits for Homebound, Terminal, or Long-term Care		
Home Health Care	50% of Eligible Charges	50% of Eligible Charges
Hospice Services	None	Not Covered
Other Medical Services and Supplies		
Ambulance, Appliances/Equipment, Blood, Dialysis, Injections, Physical Therapy, Occupational Therapy, or Speech Therapy	50% of Eligible Charges	50% of Eligible Charges
Medical Foods	20% of Eligible Charges	20% of Eligible Charges
Special Benefits for Health Assessment, Health Education, and Disease Management		
HealthPass, Disease Management Programs, Health Appraisal [4]	None	Not Covered

HMSA Dual Coverage Prescription Benefits

HMSA

The following summarizes HMSA's dual coverage prescription drug benefits.

Benefits		Member Pays
Retail Pharmacy (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Retail Pharmacy—Generic, Brand Name, Insulin, Diabetic Supplies, oral Contraceptives, diaphragms	Eligible charges exceeding plan payment of up to $15	All charges exceeding plan payment of up to $15
Mail Order Prescription Program (90 day supply)		
Mail-Order program—Generic, Brand Name, Insulin, Diabetic Supplies	Eligible charges exceeding plan payment of up to $30	Not Covered

Royal State National Insurance Company, Limited Dual Coverage Benefits

The Royal State National dual-coverage benefits plan reimburses the member's out-of-pocket costs paid for medical care up to the maximum amount per month shown below. Medical care means the diagnosis, cure, mitigation, treatment or prevention of disease, prescribed drugs, and treatments affecting any part or function of the body. Medical care must be primarily to alleviate or prevent a physical or mental defect or illness, and includes limited amounts paid for transportation to get medical care. Only expenses for medical care, which the member has paid, and which costs are not recoverable from any other person including any insurance policy, are eligible for reimbursement under the Royal State National dual-coverage benefits plan.

This summary describes plan highlights only. Please refer to Plan Certificate and Master Policy for benefit details, limitations and exclusions.

Plan Provisions	
Annual Deductible	Not Applicable
Annual Copayment Maximum	Not Applicable
Maximum Reimbursement Per Month	
Bargaining Units 01, 10, 20, 33, 61, 70 & 90	
Single Coverage	$138.00*
Family Coverage	$329.00*
*Benefit amount may change based on collective bargaining agreements.	
All Other Bargaining Units	
Single Coverage	$40.00
Family Coverage	$125.00

Royal State National Insurance Company, Limited
Dual Coverage Benefits

Medical Care Expenses Eligible for Reimbursement		
Acupuncture	Drug addiction treatment	Massage therapy
Ambulance	Eyeglasses	Medical services
Appliances/medical equipment	Eye surgery	Nutritional supplements
Birth control pills	Fertility enhancement	Prescription drugs
Chiropractic care	Hospital services	Surgical services
Contact lenses	Laboratory and x-ray	Weight-loss program
Dental services	Learning disabilities	

Carry forward Benefit. The maximum reimbursement amount is per month as described above. If the out-of-pocket expenses for medical care are less than the monthly maximum amount, the unused benefit amount will be carried forward to future (subsequent) months, but no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier. If the member's out-of-pocket expenses for medical care are greater than the monthly maximum amount, additional reimbursement for the same out-of-pocket medical care expenses may be paid in future (subsequent) months, but no more will be paid than the allowable monthly maximum amount, and no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier.

Claim Submission Requirements

1. You are responsible to collect and keep all receipts or statements that show that you have paid out-of-pocket medical care expenses incurred during the plan year.

2. You must fill out a claim form approved by Royal State National and attach copy of all receipts or statements as proof of your out-of-pocket paid expenses. The dates of service must be clearly itemized with your out-of-pocket expense indicated. Your reimbursement is based on the date of service, not when the service was paid for. For additional rules and requirements, you must follow the Company's claim form instructions.
3. All services for out-of-pocket reimbursement must be received or incurred during the plan year.
4. Royal State National must receive your claim by the last day of a month in order to be processed for that month. If your claim is received after the last day of the month, your claim will be processed the following month.

Timely Submission of Claims Royal State National must receive your claims before the end of the 90-day period after the end of the plan year or after your termination date, whichever is earlier. The Plan will not pay any claims received after this 90-day period.

Payment of Benefits Approved claims shall be paid on monthly basis and after the close of the month All reimbursement payments are payable directly to you.

Plan Certificate and Claim Forms. The Company will mail you your plan certificate and claim form within 15 business days from the date the Company receives your enrollment information from the Hawaii Employer-Union Health Benefits Trust Fund. A new claim form will be enclosed with every reimbursement benefit payment to you. For additional claim forms or questions, please contact Royal State National at (808) 539-1621 or toll free 1-800-890-9022.

This summary is intended to provide a condensed explanation of plan benefits. Please refer to the respective plan brochures and certificates for complete information on benefits, provisions, limitations or exclusions. In the case of a discrepancy between these descriptions or comparisons and the language contained within the respective plan certificates, the latter will govern.

Mutual Benefit Association of Hawaii

ChiroPlan Chiropractic Coverage

Mutual Benefit Association of Hawaii, through ChiroPlan Hawaii, Inc. is the provider of chiropractic benefits. The plan description provided in this summary of benefits shows highlights of the plan benefits. Please refer to the plan certificate for complete information on benefits, provisions, limitations and exclusions. In the errant case of a discrepancy between these descriptions and the provisions contained in the plan certificate, the latter will govern. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website, www.eutf.hawaii.gov.

All three of the medical plan options (PPO, HMO or dual-coverage) described on the previous pages include these chiropractic benefits. In order to use these benefits you must use ChiroPlan doctors. ChiroPlan may be contacted at:

ChiroPlan Hawaii. Inc.
711 Kilani Avenue, Suite 3
Wahiawa, HI 96786
Telephone: 808-621-4774
Toll-free: 800-414-8845 (Neighbor Islands)
Fax: 808-621-0006
Website: www.chiroplanhawaii.com

	ChiroPlan Provider	Non-ChiroPlan Provider
Maximum # of Office Visits Per Year	20	Not Covered
Office Visit Copay	$15.00	Not Covered
Therapy Modalities*	No Charge	Not Covered
X-Ray**	No Charge	Not Covered
Lab	Not Covered	Not Covered
Chiropractic Appliances	Not Covered	Not Covered
Emergency/Urgent Care	Not Covered	Not Covered
Out-of-Network	Not Covered	Not Covered
Alternative Medical Services***	Not Covered	Not Covered

* Therapy Modalities Include: Ultrasound, Ice Packs, Heat Packs, Electrical Muscle Stimulation and other approved therapies.

** Routine x-rays: Two (2) views per body region, per calendar year (when performed in a ChiroPlan doctor's office).

*** Alternative Medical Services Includes: Hypnotherapy, Acupuncture, Behavior Training, Sleep Therapy, etc.

HDS Dental Plan

HDS
Hawaii Dental Service
DELTA DENTAL

Summarized below are the dental benefits provided through Hawaii Dental Service (HDS). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the HDS Customer Service Department at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248. You may also obtain information from the HDS website, www.deltadentalhi.org.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	$2,000/ person
Deductible Per Calendar Year (does not apply to benefits covered at 100%)	$25/ person
Diagnostic	
Examinations (twice per calendar year)	100%
Bitewing x-rays (twice per calendar year)	100%
Other x-rays (full mouth x-rays limited to once every three years)	100%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	100%
Stannous fluoride (once per calendar year through age 19)	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	100%
Restorative	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings, limited to anterior (front) teeth Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	80%
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings) Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	60%
Endodontics	
Pulpal Therapy	80%
Root canal treatment, retreatment, apexification, apicoectomy	80%
Periodontics	
Periodontal scaling and root planing – once every two years	80%
Gingivectomy, flap curettage and osseous surgery - - once every three years	80%
Periodontal maintenance – twice per calendar year	80%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	60%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	60%
Repairs, adjustments, relines and rebase	60%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	80%
Adjunctive General Services	
Consultations by Specialist not performing services	80%
Office visits (injury related)	80%
Sedation General and IV – Oral Surgery Only	80%
Palliative (Emergency) treatment (for relief of pain but not to cure)	100%

HDS Dental Plan continued

HDS
Hawaii Dental Service
DELTA DENTAL

Benefit	Plan Coverage
Orthodontics Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case paid in 8 quarterly payments of $125. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If the group removes the orthodontic benefit, coverage will end on the last day of the benefit change month.	50%

Shaded areas indicate coverage after 12 months of continuous enrollment.

Benefit Exclusions

Your HDS plan does not cover the following services:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Vertical dimension, occlusal adjustment, equilibration, periodontal splinting, restoration of tooth structure lost from wearing away, restoration for tooth malalignment, jaw movement recordings and treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services if services were started prior to the date the patient became eligible under this group plan.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to subscriber by a dentist.
- All other services not specified in the Schedule of Benefits, which is available from your employer.

Multi-state Coverage

If you or your family reside or travel outside Hawaii and need dental care, your HDS plan will provide you coverage. HDS is a member of Delta Dental Plans Association, the largest dental benefits provider in the nation. So if your job takes you out of state or your son or daughter attends school on the Mainland, the charges of participating dentists would be capped by their respective state's eligible fees for covered services.

While on the Mainland, you can maximize your benefits by selecting a dentist who participates with Delta Dental. To obtain a list of participating Delta dentists in that zip code, visit the Delta Dental web site at www.deltadental.com and use the 'Dentist Search' capability. Or you may call our Customer Service Department toll-free at (800) 232-2533 ext. 248 and we will send you a list of participating dentists in your area.

Visiting a Participating Delta Dentist

If the dentist you have selected is a participating HDS or Delta (on the Mainland) dentist, he/she will submit the claim directly to HDS for you. Be sure he/she obtains HDS's mailing address from the back of your member identification card. HDS's payment will be based upon the participating dentist's eligible fees in his/her state. (HDS uses the National Provider File to obtain these fees.) Your share will be limited to the difference between the participating dentist's eligible fee and HDS's payment amount.

Visiting a Non-Participating Dentist

When you visit a non-participating dentist, in most cases you will need to pay in full at the time of service. On your first visit to a non-participating dentist, advise the dentist that you have an HDS dental plan and present your HDS member identification card. Your dentist will render services and may send you the completed claim form (universal ADA claim form) to file with HDS. Mail the completed claim form to the following address for processing:

HDS - Dental Claims
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

HDS will pay for services rendered up to your benefits coverage amount. Please be aware that your non-participating dentist's fees may be higher than a participating dentist's fees, and the fees used to calculate your benefit are lower than participating dentists' eligible fees. You are responsible for the difference between your non-participating dentist's fees and HDS's payment amount.

HDS
Hawaii Dental Service
DELTA DENTAL

Dual Coverage Dental Plan

As with the medical plan, you have the option to elect the Dual Coverage Dental plan if you have primary dental coverage from the private sector or federal government. This plan is also offered by HDS. Please refer to page 25 for contact information for HDS.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	$800/ person
Diagnostic	
Examinations (twice per calendar year)	50%
Bitewing x-rays (twice per calendar year)	50%
Other x-rays (full mouth x-rays limited to once every three years)	50%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	50%
Stannous fluoride (once per calendar year through age 19)	50%
Space maintainers (through age 17)	50%
Sealants (through age 18) One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	50%
Restorative	
Amalgam (silver-colored) fillings	40%
Composite (white-colored) fillings, limited to anterior (front) teeth Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	40%
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings) Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	30%
Endodontics	
Pulpal Therapy	40%
Root canal treatment, retreatment, apexification, apicoectomy	40%
Periodontics	
Periodontal scaling and root planing – once every two years	40%
Gingivectomy, flap curettage and osseous surgery - - once every three years	40%
Periodontal maintenance – twice per calendar year	40%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	30%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	30%
Repairs, adjustments, relines and rebase	30%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	40%
Adjunctive General Services	
Consultations by Specialist not performing services	40%
Office visits (injury related)	40%
Sedation General and IV – Oral Surgery Only	40%
Palliative (Emergency) treatment (for relief of pain but not to cure)	50%

VSP Vision Plan

Summarized below are the vision benefits provided through Vision Service Plan (VSP). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or call VSP's Customer Service Department, Hawaii Office: 808-532-1600 or toll-free from the neighbor islands at 800-522-5162; Customer Call Center (mainland US): 800-877-7195. You may also obtain information from the VSP website, www.vsp.com.

	VSP Doctor	*Out-of-Network Reimbursement*
Eye Exam	$10 Co-payment	After Co-pay
Every 12 Months*	No Charge	Up to $40
Materials (lenses and/or frame)	$25 Co-payment	Not Applicable
Every 12 Months*		
Single Vision	No Charge[1]	Up to $40
Bifocals	No Charge[1]	Up to $60
Trifocals	No Charge[1]	Up to $60
UV Coating	No Charge	No Additional Benefit
Frames		
Every 24 Months*	Covered up to $105 Allowance[2]	Up to $40
Contacts (in lieu of glasses)		
Every 12 Months*	Covered up to $100 Allowance[3]	Up to $100

* Based on your last date of service.

1 Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing.

2 If you choose a frame valued at more than your allowance, you'll save 20% on you out-of-pocket cost for frames.

3 Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Dual Coverage Vision Plan

As with the medical and dental plans, you have the option to elect the Dual Coverage Vision plan if you have primary vision coverage under another vision plan. This plan is also offered by VSP.

Eye Exam	

Life Insurance Benefits

Aetna

Life insurance benefits are underwritten by Aetna Life Insurance Company. This is a summary of the plan benefits. For complete information and provisions, please refer to your certificate provided by Aetna, contact Aetna Customer Service at 1-866-227-9954 or visit their website, www.aetna.com.

Submit claims to: Aetna Inc. Life Service Center
151 Farmington Avenue – RE52
Hartford, CT 06156-3007
Fax Number for Claim Submission: 1-800-238-6239

In the event of your death, the life insurance company will pay your beneficiary the applicable amount of life insurance benefits as shown below:

Classification	Benefit Amount
Under age 65	$26,000
Age 65 through 69	$16,900
Age 70 through 74	$11,700
Age 75 through 79	$7,800
Age 80 and over	$5,200

The death benefit amount will be reduced by any amount previously paid under the Accelerated Death Benefit provision, described below.

Designation of Beneficiary Form

Please download the form from the EUTF website at www.eutf.hawaii.gov or call the EUTF to have it sent to you.

Classification Change Date

Any change in your life insurance classification will become effective on the date of your 65th, 70th, 75th, and 80th birthday. When you retire from active employment, your benefit amount will change. Refer to the Retiree Reference Guide for specific information.

Accelerated Death Benefit

If, while covered under this life insurance plan you become terminally ill, you may request that the life insurance company pay an Accelerated Death Benefit. Your physician must certify that you suffer from a terminal illness and have a life expectancy of 12 months or less. Upon approval of your request, the insurance company will pay up to 75% of your life insurance benefits, with a minimum payment of $5,000. A nominal amount of interest is charged for the accelerated payment, as defined in your life insurance certificate. The Accelerated Death Benefit payment will be reduced by an interest discount to account for the early payment.

Life Insurance Conversion

If your life insurance ceases because of termination of employment or is reduced due to age, you may convert to an individual policy. You must apply within 31 days of the following events:

- Your insurance ends because you are no longer eligible, you may convert to an amount of life insurance equal to the amount of insurance you had prior to your termination.
- When you reach age 65, 70, 75, and 80 as an active employee and at retirement, you may convert to the amount being reduced.

If you die within the 31-day conversion period, and before the individual policy goes into effect, the amount payable is the maximum amount you could have converted. This amount applies even if you had not applied for or paid the first premium on the individual policy.

Important Notices

Many federal and state laws guide the administration of all health benefits insurance plans. While official insurance contracts actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and your official insurance documents, the official insurance documents will prevail.

If you have any questions about this section, please call the Hawaii Employer-Union Health Benefits Trust Fund (the EUTF) at 808-586-7390.

Women's Health & Cancer Rights Act

Your health insurance plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductibles, co-payments, and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call your insurance carrier or the EUTF at 808-586-7390.

Newborns' & Mothers' Health Protection Act

Generally, group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery, or
- Less than 96 hours following a caesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

Your health insurance plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under the health insurance plan,
- Name and last known address of each child to be covered under the health insurance plan,
- Type of coverage to be provided to each child, and
- Period of time coverage will be provided.

Send QMCSOs to the EUTF, which is your Plan Administrator. Upon receipt, the EUTF will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan.

National Medical Support Notices

The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs). These Notices are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order. Upon receipt of the NMSN, the Employer will, within 40 business days, return the Notice to the state agency if the specified coverage is not available for one of the reasons set forth on the Notice, or forward the Notice to the EUTF, the Plan Administrator, if the specified coverage is available.

If the Employer forwards the Notice to the EUTF, the EUTF will, within 40 business days, return the Notice to the state agency and/or the parties concerned to inform them whether the Notice constitutes a QMCSO.

If the Notice qualifies, the EUTF will notify the state agency either that the child(ren) is/are currently enrolled or will be enrolled in the coverage available under the EUTF.

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state agency of the coverage options from which you may elect coverage. In this event, the EUTF will also

notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

If the Notice is not qualified, then within 40 business days, the EUTF will notify the state agency and the parties involved, the specific reason(s) why the Notice failed to qualify. The EUTF may also provide additional notifications as provided for in the NMSN's instructions.

Continuation of Group Health Coverage Under COBRA: Initial Notice

A federal law, commonly known as "COBRA," requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event" (listed below).

The section serves as your initial notice of your rights and obligations under COBRA. It is subject to change without warning, as interpretations or changes in the law do occur. Please read this notice carefully, share it with your family, and keep it in your file.

Qualifying Events

Employees

If you are an employee covered under a group health plan, you (and your covered dependents) may elect COBRA coverage if you lose your group health coverage due to either of these "qualifying events":

- Termination of your employment (for reasons other than gross misconduct), or
- Reduction in your work hours causing you to be ineligible for health benefits insurance.

Covered Spouses

If you are the covered spouse of an employee enrolled in a group health plan, you may elect COBRA coverage if you lose group health coverage due to any of these "qualifying events":

- Termination of your spouse's employment (for reasons other than gross misconduct), or
- reduction in your spouse's work hours causing him or her to be ineligible for Plan benefits,
- Death of your spouse,
- Divorce or legal separation from your spouse, or
- Employee-beneficiary becomes entitled to Medicare benefits.

Covered Children

Dependent children who are covered under a group health plan have the right to elect COBRA coverage if they lose coverage under the Plan due to any of these "qualifying events":

- The employee-parent's employment stops (for reasons other than gross misconduct), or work hours are reduced resulting in ineligibility for Plan benefits,
- Death of the employee-parent,
- Parents' divorce or legal separation,
- Employee-parent becomes entitled to Medicare benefits, or
- Dependent child ceases to be a "dependent child" under the health insurance plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment or the death of the employee, your employer must notify the Plan Administrator of the Qualifying Event. The employee will not need to notify the EUTF of the occurrence of any of these three Qualifying Events.

You Must Give Notice of Some Qualifying Events

For the other initial Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the Plan Administrator with notice of the Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date of the loss of coverage under the Plan.
You must provide this notice in writing by appropriately completing the attached "Notice of a COBRA-Related Event." For detailed instructions on completing this Notice, the documentation required to accompany the Notice and the procedures for submitting the Notice, see the EUTF's website or contact the Plan Administrator. If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE..

Cost of Coverage

Insurance carriers providing coverage for the EUTF beneficiaries will administer the billing and collection of COBRA premiums.

You will be charged the full premium under the group health plan for COBRA coverage, plus a 2% administrative charge. If you are disabled and you extend your coverage for more than 18 months, you will have to pay the full cost of coverage plus another 50% of the premium for months 19 through 29.

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months.

The COBRA continuation coverage periods described above are maximum coverage periods. COBRA coverage can end before the maximum coverage period described in this Notice for several reasons. For more information refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

There are three ways in which this 18-month period of COBRA continuation coverage resulting from a reduction in hours or employment or termination of employment can be extended.

Disability extension of 18-month period of continuation coverage

If a Qualified Beneficiary in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum COBRA coverage period of 29 months. For more information regarding this disability extension of the COBRA coverage period, the timeframe and procedures for providing the notice of disability and the cost of COBRA coverage during any disability extension period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving 18 (or 29) months of COBRA continuation coverage resulting from the covered employee's termination of employment or reduction in hours of employment (or during the disability extension period following either of these Qualifying Events), the spouse and dependent children in your family who are receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for up to a maximum of 36 months of COBRA continuation coverage, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (This extension in the COBRA coverage period is not available under the Plan when a covered employee becomes entitled to benefits under Medicare.) For more information regarding second Qualifying Events and the timeframe and procedures for providing the notice of a second Qualifying Event, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Medicare extension for a spouse and dependent children

If an employee loses coverage under the Plan due to a termination of employment or reduction of hours of employment that occurs within 18 months after the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both), then the maximum coverage period for the spouse and dependent children (but not the employee) will be up to 36 months from the date the employee became entitled to Medicare benefits. However in this situation, the covered employee's maximum coverage period will be 18 months. For more information regarding this Medicare extension of the COBRA coverage period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Children Born To or Placed for Adoption with the Covered Employee during a Period of COBRA Continuation Coverage

A child born to or adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the covered employee is a Qualified Beneficiary, the covered employee has elected COBRA continuation coverage for himself or

herself. For more information regarding a newly acquired dependent child's COBRA, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Alternate Recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights under COBRA as a eligible dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent under the eligibility requirements of the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you must notify the Plan Administrator of any changes in the addresses of family members by submitting a fully completed Enrollment Change form (EC-1) to the Plan Administrator. The EC-1 form is available from the Plan Administrator. You should also keep a copy, for your records, of any notices or forms you send to the Plan Administrator.

Plan Contact Information

For more information about COBRA, you may contact the Plan Administrator at the following address. You may also view the EUTF's "COBRA Notice" on the website at: www.eutf.hawaii.gov.

Hawaii Employer-Union Health Benefits Trust Fund

P.O. Box 2121

Honolulu, HI 96805-2121

Telephone: (808) 586-7390

Toll Free: (800) 295-0089

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

Effective date of this notice is March 1, 2005.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information.

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you, and
- Follow the terms of the notice that is currently in effect.

HIPAA also requires the EUTF to tell you about:The EUTF's uses and disclosures of your medical information,

- Your privacy rights with respect to your medical information,

- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the EUTF is allowed to use and disclose your medical information will fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

For EUTF Operations: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health

Plan, Hawaii Dental Service, Vision Service Plans, ChiroPlan
Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied claim or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates

before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications:

You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you — as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information

from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

Questions?

If you have any questions about this notice, contact the EUTF Privacy Officer, at the address below.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the EUTF Privacy Officer at the following address:

CONTACT INFORMATION

Mailing Address:	P.O. Box 2121 Honolulu, HI 96805-2121
Location Address:	201 Merchant Street #1520 City Financial Tower Honolulu, Hawaii

Telephone Numbers

Local Number:	(808) 586-7390
Toll-Free Number	1-800-295-0089
Fax Number:	(808) 586-2161
Email Address:	eutf@hawaii.gov
Website Address:	www.eutf.hawaii.gov

Retiree Health Benefit Brochure

Supplement to 2005 Reference Guide for Retirees

Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2006

INTRODUCTION

This benefits brochure supplements the 2005 Reference Guide for Retirees. The brochure only includes changes, additions and deletions to current health benefit plans. In addition, it updates and/or re-emphasizes key procedures and instructions as to which each retiree and surviving spouse must comply. This brochure and the 2005 reference guide are available at the EUTF's website, www.eutf.hawaii.gov, where you can access them when you have questions about your benefits.

2006 OPEN ENROLLMENT

The 2006 Open Enrollment period is scheduled from April 17 through May 19, 2006. This brochure is being sent to all retirees and surviving spouses along with a pre-completed Open Enrollment Form for Retirees (OE-2) that contains information on file with the EUTF as of March 1, 2006. Changes that were not entered in the EUTF files prior to March 1, 2006 are not included on your pre-completed open enrollment form. The EUTF has scheduled several Open Enrollment informational sessions for your convenience. These sessions will be your opportunity to obtain more information regarding your health benefits. Representatives from all the EUTF health plans will be present to field your questions or concerns

Please review the information on your pre-completed open enrollment form for accuracy and make any changes that are needed. You may cross out any information that should be deleted and/or print legibly any new information. **If you have no changes, you are done with open enrollment. You will be reenrolled in the same plans and coverage that you currently have. Otherwise return the changed and signed open enrollment form by May 19, 2006.**

Since there are only minor changes to the retiree plans there are only a few Open Enrollment informational sessions scheduled for retirees (see below). If you cannot attend any of the retiree sessions, you may contact the EUTF directly or attend one of the active employee Open Enrollment sessions. Please check our website, www.eutf.hawaii.gov, or call the EUTF at (808) 586-7390 for the locations, dates and times of all the Open Enrollment sessions in your area.

OPEN ENROLLMENT LOCATIONS FOR RETIREES

OAHU

Leeward Community College
96-045 Ala Ike
Pearl City, HI 96782

Kahala Community Center
4495 Pahoa Avenue
Honolulu, HI 9616

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

Windward Community College
45-720 Keaahala Road
Kaneohe, HI 96744

HAWAII

Kona Armory
81-1032 Nani Kupuna Rd.
Kealakekua, HI 96740

Aunt Sally Kaleohano's's Luau Hale
799 Piilani Street
Hilo, HI 96720

OPEN ENROLLMENT LOCATIONS FOR RETIREES

MAUI

Waikapu Community Center
22 E. Waiko Rd.
Wailuku, HI 96793

KAUAI

Kauai War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

2006 OPEN ENROLLMENT SCHEDULE FOR RETIREES

Date	Time	Location
04/18/06	9:00 a.m.	Leeward Community College
04/18/06	1:00 p.m.	Leeward Community College
04/21/06	10:00 a.m.	Kona Armory
04/25/06	9:00 a.m.	Kahala Community Center
04/25/06	1:00 p.m.	Kahala Community Center
05/01/06	9:00 a.m.	Waikapu Community Center
05/05/06	9:00 a.m.	Windward Community College, Akoakoa Room
05/05/06	1:00 p.m.	Windward Community College, Akoakoa Room
05/08/06	9:00 a.m.	Kauai War Memorial Convention Center
05/10/06	9:00 a.m.	Aunt Sally Kaleohano's Luau Hale
05/10/06	1:00 p.m.	Aunt Sally Kaleohano's Luau Hale
05/10/06	9:00 a.m.	Capitol Auditorium
05/10/06	1:00 p.m.	Capitol Auditorium

What is this new Medicare Prescription Drug Plan (Medicare Part D)

WHAT IS MEDICARE PART D?

Beginning January 1, 2006, new Medicare prescription drug plans became available to people with Medicare. Many insurance companies and other private companies have been approved by Medicare to offer these drug plans. Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join, you will pay a monthly premium *and* pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose. You have the right to enroll in a Medicare Part D, prescription drug program.

If you currently have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), you can enroll in a Medicare prescription drug plan until May 15, 2006. If you enrolled prior to December 31, 2005, your Medicare prescription drug plan coverage began on January 1, 2006. If you enroll any month prior to May 15, 2006, your coverage will be effective the first day of the month after the month in which you join. In general, you may enroll or change plans once each year between November 15 and December 31.

WHAT DOES THIS MEAN TO ME?

In October 2005, the EUTF sent all retirees and their dependents eligible for Medicare a Notice of Creditable Coverage. This indicated that your current prescription drug coverage was equal to or better than the coverage provided by Medicare for prescription drugs. The notice also instructed each recipient to keep the notice in case you enroll in Medicare Part D in the future. The notice will ensure that the retiree is not penalized for enrolling at a later date. On the Medicare website, it is recommended that "if your employer . . . covers as much as or more than a Medicare prescription drug plan you can . . . keep your current drug plan." Since the EUTF prescription drug coverage is better than or equal to Medicare Part D, you do not need to do anything else regarding Medicare Part D.

If you do choose to enroll in a Part D plan, your enrollment can affect you differently based on the medical plan in which you are currently enrolled. The difference is especially important to our Medicare-eligible participants who are enrolled in the Kaiser Senior Advantage plan. For Kaiser members on the Senior Advantage plan, your enrollment in Medicare Part D is automatic at no cost to you. If you enrolled in a Medicare Part D plan other than Kaiser, you will become ineligible to remain a member of the Kaiser Senior Advantage medical plan. You will either need to disenroll from the non-Kaiser (new) Part D plan so that you can remain on Kaiser Senior Advantage, or your medical plan will automatically be changed to HMSA. Medicare requires that if you are enrolled in the Kaiser Senior Advantage medical plan, you must also be enrolled with Kaiser for the prescription drugs plan. If you desire to remain a Kaiser Senior Advantage member, you should not enroll in another Part D plan.

What do I have to do to ensure that my health benefits continue?

1. You should have received a pre-completed Open Enrollment form (OE-2) that shows the plans in which you are currently enrolled. Review this form to ensure that the plans noted are the plans you want for the upcoming plan year. If the form is incorrect or you want to change your plans or coverage, make the changes on the form, sign the form, and return it to the EUTF no later than May 19, 2006. Please ensure that any changes you make are legible.

2. If you have no changes, you are done with open enrollment. You do not need to sign or return the pre-completed Open Enrollment form. You will be re-enrolled in the same plans and coverage that you currently have.

3. As described below, if you are Medicare eligible (age 65 or under 65 and disabled), you may be required to enroll in Medicare Part B in order to be eligible for the EUTF retiree health benefit plans. If you are eligible and have yet to enroll with Medicare Part B, contact the EUTF immediately.

4. If you are Medicare eligible and want to continue enrollment with the Kaiser retiree plan, you also need to enroll with Medicare. You need to complete the Medicare Senior Advantage enrollment form that Kaiser will send for you to complete. Failure to do so may terminate your enrollment with Kaiser. Please contact Kaiser Permanente for assistance.

5. **FOR KAISER ENROLLEES ON THE MAINLAND.** If you are a retiree or surviving spouse living outside of Hawaii and choose to enroll with Kaiser, your enrollment with the EUTF only ensures that any employer contribution toward your health premiums is made. You still need to contact the nearest Kaiser Permanente plan and enroll with that plan. Your plan coverage and premiums may differ than the Kaiser plan in Hawaii. If the premiums exceed the premiums in Hawaii, you will be responsible for the difference. In addition, the benefits noted in any EUTF correspondences, brochures or guides do not reflect the benefits or the pricing that you will have with your local carrier.

Medicare Reminders

1. If you are Medicare eligible (age 65 or under age 65 and disabled), you must enroll in the Medicare Part B plan to be eligible for coverage under the EUTF retiree health benefit plans. Act 136, SLH 1999 established this requirement for all retirees and their spouses who became eligible for Medicare Part B after June 24, 1999.

2. If you were born prior to June 25, 1934, you were excluded from this requirement to enroll in Medicare Part B. However, if you did enroll and are paying your own premium for Medicare Part B, you are eligible to be reimbursed for your Medicare Part B premiums. Please provide proof of your enrollment in Medicare Part B by sending a copy of your Medicare card to the EUTF. If you are eligible for reimbursement for your premiums, **reimbursements will begin the first day of the month after the EUTF receives a copy of your Medicare card.**

3. Reimbursements are distributed each quarter in early January, April, July and October. If your Medicare card indicates a Medicare start date after the EUTF receives a copy of that card, your reimbursement will begin the first day of the month you are enrolled in Medicare. If the Medicare card indicates a start date before the EUTF receives a copy of that card, your reimbursement will not be retroactive and will begin the first day of the next month after EUTF receives a copy of your card

Plan Benefit Changes Effective July 1, 2006

The health benefit plan coverage for the period July 1, 2006 – June 30, 2007 will not change from the current plan year with the exception of the Kaiser Permanente medical plan and the Aetna life insurance plan. A summary of the Kaiser Permanent medical plan changes and the revised life insurance amounts are shown below. Please refer to the 2005 Reference Guide for Retirees or contact the insurance carriers to obtain an updated benefit brochure.

Long Term Care Insurance. The Long-Term Care plan, previously offered by Hartford Life Insurance, is no longer offered by the EUTF. However, those individuals that are currently covered under the plan will continue to be covered and will continue to be billed for the premium. Your coverage has <u>not</u> been cancelled. You coverage will continue for as long as you pay your premiums. Be advised that the insurance company has the right to increase your

premiums after January 1, 2006. However, your premiums will be increased only if they are increased for all people covered by the plan.

MEDICAL AND PRESCRIPTION DRUGS PLAN

HMSA Medical and Prescription Drugs plan

Health benefits for all retirees remain the same. HMSA periodically reviews your health plans to ensure that these health plans provide you with quality health plan benefits in compliance with state and federal laws and are structured to best manage health care costs.

This document is for general information use only and is not for use as the certificate for the plan. The *Guide to Benefits* will contain complete information on these changes as well as, other benefits and applicable exclusions and limitations of your plan. In the case of a discrepancy between this summary and the language contained in the *Guide to Benefits* or plan certificate, the *Guide to Benefits* or plan certificate take precedence. You can find this Guide to Benefits at the HMSA website for EUTF at www.hmsa.com/portal/ and or you may access this website through the EUTF website, www.eutf.hawaii.gov by clicking on the "Links to Carrier" line. HMSA has created a special site for EUTF members.

The changes made were either administrative or language clarifications in nature and applies to the HMSA PPO, HMSA Dual and the HMSA Prescription Drugs plans, as appropriate. The most significant administrative changes dealt with precertification requirements for some services to reflect the current policies. For a complete listing of these changes, please contact your local HMSA officer or visit the HMSA website noted above.

KAISER PERMANENTE Non-Medicare Medical Plan for Retirees

This is only a summary of 2006 Kaiser Permanente plan changes which are effective July 1, 2006. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, or to obtain a packet of benefit information, please log on to my.kaiserpermanente.org/hi/eutf or contact the Customer Service Center at (808) 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Summary of 2006 Important Changes

Benefit and contract changes:
1. **Office visit copayment.** Increase from $12 to $14 per visit.
2. Inpatient/Outpatient lab, imaging, and testing. Currently no charge, changed to a 10% copay for these services.
3. Preventive screening services. Certain preventive screening services will not be subject to the 10% copay, and instead be covered at no charge. Office visit copay will be charged if applicable. The list of services that fall under the preventive screening benefit is in the Service Agreement.

4. Physical, occupational, and speech therapy. There will no longer be a two-month limit on these therapies. However, keep in mind that only short term therapy is covered. As determined by a Kaiser Permanente physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.
5. Serious mental illness parity. The serious mental illness (parity) benefit has been expanded to include obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression.
6. Live or work. Subscribers must live or work in the Hawaii service area to be enrolled in a Kaiser Permanente plan. Family dependents must live in the Hawaii service area to enroll (or continue to be enrolled) in a Kaiser Permanente plan.
Benefit and contract clarifications:
1. Office visits. An office visit is defined as evaluation and management services, which may include some or all of the following: examination, history, and/or medical decision making. Office visits do not include, for example, outpatient procedures. Outpatient procedures would be covered per the member's outpatient procedures benefit.
2. Physical, occupational, and speech therapy. Physical, occupational, and speech therapy deficits due to developmental delay are not covered.
3. Family dependent child. The definition of "child" for purposes of enrolling as a family dependent is defined in the EUTF Administrative Rules.

For details on your benefit coverage, exclusions, and plan terms, please refer to EUTF's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

NOTE: General reminder for all members:
Unless explicitly described in a particular benefit section, each medical service or item is covered according to its relevant benefit section. For example, labs or blood related to a hospital stay are not covered under the hospital benefit. Labs related to a hospital stay are covered under the lab benefit. Blood received during a hospital stay is covered under the blood benefit.
Kaiser Permanente's web services now allow you to make appointments, order prescription refills, and more. For more information log on to my.kaiserpermanente.org/hi/eutf or contact the Customer Service Center at (808) 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

KAISER PERMANENTE SENIOR ADVANTANGE Medical Plan for Retirees (Medicare)

This is only a summary of 2006 Kaiser Permanente plan changes which are effective July 1, 2006 and is an addendum to the 2005 Reference Guide for Retirees. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, or to obtain a packet of benefit information, please log on to my.kaiserpermanente.org/hi/eutf or contact the Customer Service Center at (808) 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Summary of 2006 Important Changes

Benefit and contract changes:
1. **Office visit copayment.** Increased from $12 to $14 per visit.
2. **Prescription Drugs.** The Medicare Part D prescription drugs plan specifies the types of prescription drugs to be included in the formulary. In some cases, costs for some brand-name drugs now require a $40 copayment. As a result of Medicare Part D, contraceptives, home infusion drugs and drug coverage in a long term care facility are now part of our formulary.
3. Physical, occupational, and speech therapy. There will no longer be a 2 month limit on these therapies. However, keep in mind that only short term therapy is covered. As determined by a Kaiser Permanente physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.
4. Serious mental illness parity. The serious mental illness (parity) benefit has been expanded to include obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression.
5. Where you live. Subscribers must live in the Hawaii service area to be enrolled in the Hawaii Kaiser Permanente plan. Except for students, family dependents must live in the Hawaii service area to be enrolled in the Hawaii Kaiser Permanente plan. Retirees or survivors of retirees living on the U.S. mainland must enroll in the local Kaiser Permanente plan in their area.
Benefit and contract clarifications:
1. Office visits. An office visit is defined as evaluation and management services, which may include some or all of the following: examination, history, and/or medical decision making. Office visits do not include, for example, outpatient procedures. Outpatient procedures would be covered per the member's outpatient procedures benefit.
2. Physical, occupational, and speech therapy. Physical, occupational, and speech therapy deficits due to developmental delay are not covered.
3. Family dependent child. The definition of "child" for purposes of enrolling as a family dependent is defined in the EUTF Administrative Rules. **4. Student coverage up to age 24.** Unmarried dependent children who are full-time students and have the same legal address as the subscriber are covered up to their 24th birthday.
5. Enrollment in the Senior Advantage plan. All Kaiser Permanente subscribers are required to submit an enrollment form upon attaining age 65 to continue to be enrolled with Kaiser Permanente. Kaiser will provide you with an enrollment form that is in addition to the EUTF's EC-2 enrollment form. This enrollment is required by Medicare and must be submitted to Kaiser Permanente on a timely basis. Failure to do so can result in the termination of your enrollment with Kaiser Permanente.

All care and services must be coordinated by a Kaiser Permanente physician.

For more information about this plan, please call the Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or TTY/TDD 1-877-447-5990. We are open from 8:00 am - 5:00 pm, Monday through Friday, (except holidays) and Saturday from 8:00 am - noon.

Drug formulary: Kaiser Permanente periodically adds or removes drugs from the formulary (the list of drugs dispensed by Kaiser Permanente). Under certain circumstances, selected drugs may also be moved from one benefit category to another (for example, the drug may not be covered as a self-administered prescription or it may be covered as a medical supply). Non-formulary drugs are generally excluded from coverage. If you wish to request an exception to the drug formulary limitations, please notify your Medical Group Physician, Kaiser Permanente Pharmacist, or our Customer Service Center at the phone number listed above.

For further information on benefits, exclusions and limitations, please refer to the Senior Advantage Evidence of Coverage, Senior Advantage Summary of Benefits, Senior Advantage Benefits Schedule, and Group Medical and Hospital Service Agreement.

DENTAL

HDS Dental Plan - Your HDS benefits remain the same. The EUTF Reference Guide for Retirees published in 2005 did not indicate the correct age limitation for stannous fluoride. The correct age limitation is 19.

HDS recently launched a phone service, as another resource, called HDS DenTel. You may call HDS DenTel to find out when you are eligible for your next dental visit, obtain claims information, or even have a summary of your plan benefits faxed or mailed to you, simply by following the prompts on the phone. The number is (808) 529-9333, or toll free from the Neighbor Islands and the Continental U.S. at 1-800-232-2533, ext. 333.

The HDS Customer Service Department is also available at (808) 529-9248, or toll-free from the Neighbor Islands and the Continental U.S. at 1-800-232-2533, ext. 248

For a full description of your dental benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov. You may also obtain information from the HDS website, www.deltadentalhi.org. Certain limitations, restrictions and exclusions may apply to the plan. In the case of a discrepancy the HDS Schedule of Benefits will govern.

VISION

VSP Vision Plan – No benefit changes

LIFE INSURANCE

Effective July 1, 2006, the life insurance amount for retirees will increase to $2,372. Your life insurance is again provided at no cost to the retiree.

Premium Rates for Plans Effective July 1, 2006

Carrier	Type of Plan	Coverage	Monthly Premiums
HMSA	Non-Medicare Medical	Single	$315.42
		Family	$882.28
HMSA	Medicare Medical	Single	$201.08
		Family	$657.96
Kaiser	Non-Medicare Medical	Single	$348.20
		Family	$1,044.56
Kaiser	Medicare Medical	Single	$164.40
		Family	$493.12
HDS	Dental	Single	$29.20
		Family	$58.56
VSP	Vision	Single	$4.68
		Family	$10.06
AETNA	Life Insurance	Retiree only	$4.16

The rates shown are the cost to your employer if you are eligible for 100% contribution and only for Hawaii-based plans. Retirees enrolled in the HMSA plan are enrolled in the Hawaii-based plan. Premiums for retirees enrolled in the Kaiser plan outside of Hawaii will depend on the premiums for the Kaiser plans in their local area. Contributions for retiree premiums are based on the rates above. If your premiums are higher, you are responsible for the difference.

To Contact the EUTF:

Mailing Address: P.O. Box 2121, Honolulu HI 96805

Location Address: 201 Merchant Street, #1520, City Fiinancial Tower, Honolulu, Hawaii

Telephone Numbers

Local number: 808-586-7390 Toll-Free number: 800-295-0089

Fax number: 808-586-2161

Email address: eutf@hawaii.gov

Website address: www.eutf.hawaii.gov

Reference Guide For Retirees

Hawaii Employer-Union Health Benefits Trust Fund

Effective July 1, 2005

REPRINTED MARCH 2006

Reference Guide for Retirees

Table of Contents

INTRODUCTION

This benefits booklet is designed to help retirees understand the benefit options available and assist them to enroll or change their enrollment in the benefit plans offered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). This booklet will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits.

2005 OPEN ENROLLMENT IS EASY!

The open enrollment period is April 18 through May 20, 2005. Each retiree was mailed this booklet along with a pre-completed Open Enrollment Form for Retirees (OE-2) that contains the information that EUTF had available as of April 1, 2005. Each retiree is asked to review the information for accuracy and make any changes that are needed. You may cross out any information that should be deleted and print legibly any new information.

If you have no changes, you are done with open enrollment. You will be reenrolled in the same plans and coverage that you currently have. Otherwise return the changed and signed open enrollment form by May 20, 2005.

Since there are only minor changes to the retiree plans there are only a few Open Enrollment informational sessions scheduled for retirees. If you have questions, you may contact the EUTF directly or attend the active employee Open Enrollment sessions. Please check with our website, www.eutf.hawaii.gov, for the schedule or call the EUTF at (808) 586-7390 for locations, dates and times in your area.

Note: If you are enrolled in a Kaiser plan and living on the mainland, please contact the EUTF at 1-800-295-0089 for an information booklet regarding Kaiser enrollment requirements.

Plan Benefit Changes

HDS dental coverage will now include pulp vitality testing for emergency situations, as well as guided tissue regeneration, bone replacement grafts and soft tissue allografts for advanced periodontal disease. Titanium crowns, pontics, inlays and onlays, prefabricated steel crowns and procedures to construct new crowns under existing partial dentures are also now included. Age limits have also increased for some services, as shown in the benefit summary in this booklet.

Kaiser Permanente coverage is available to all Hawaii residents except for a few living on the southern tip of the island of Hawaii in zip codes 96718, 96772 and 96777.

The plan now has an increased copayment of $12 rather than $10, is now offering some preventive screening services without a lab/x-ray copayment, and has changed the copayment structure for contraceptive drugs and devices to 50% of costs, rather than $10 per 30-day supply.

In addition, billing charges for late payments and any outstanding balances over 60 days will be subject to an administrative charge.

Inpatient and outpatient chemical dependency benefits will be provided in accordance with state law, in which copayments and limits are the same as for any other physical disease or illness.

Long Term Care Insurance: The Long-Term Care plan, currently offered by Hartford Life Insurance, will no longer be offered to new applicants. Those individuals that are currently covered under the plan will continue to be covered and will continue to be billed for the premium. Your coverage is not being cancelled. The insurance company has the right to increase your premiums after January 1, 2006. They can only increase premiums if they are increased for all people covered by the plan.

Rates

If you were employed prior to July 1, 1996 and retire with 10 or more years of service, excluding sick leave, you will receive 100% employer contribution funding. Kaiser Permanente enrollees on the mainland may be charged a portion of the premiums if their premiums exceed the contribution amounts for retirees.

If you were employed or re-employed more than 90 days after the last day worked with a previous EUTF employer, after June 30, 1996 with less than 10 years of service, the funding of your retiree benefits will be:

Years of Service, Excluding Sick Leave	Employer Funding
10 but fewer than 15	50%
15 but fewer than 25	75%
25 or more	100%

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet
- Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable EUTF benefit plan;
- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the EUTF's rules.

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the Hawaii Revised Statutes;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries; and
- Complying with the EUTF's rules.

Enforcement Actions of the EUTF

Verifications

The EUTF may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in EUTF benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in the Administrative Rules. The Administrative Rules are available at the EUTF website, www.eutf.hawaii.gov.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required monthly contributions is not paid.to the EUTF. The notice shall be sent within fifteen days of the date on which the required monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the month immediately following the date that the required monthly contribution payment was due. When required, payments are due prior to the first day of the coverage month.

Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment as required, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the EUTF and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c).

Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the EUTF's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

The EUTF shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the EUTF.

Retiree Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF. New retirees are enrolled during the retirement counseling sessions scheduled by the Employees Retirement System. If you have any questions concerning eligibility provisions, you should call the EUTF Customer Service at 808-586-7390 or reference the Administrative Rules posted on the EUTF website, www.eutf.hawaii.gov.

Health Plans

Employee-beneficiaries. The following persons shall be eligible to enroll as employee beneficiaries in the benefit plans offered or sponsored by the EUTF:

- An employee, including an elective officer of the State, county or legislature
- A retired employee
- Surviving spouse of an employee killed in performance of duty, spouse does not remarry
- Surviving spouse of retired employee, spouse does not remarry

- Unmarried child of an employee killed in performance of duty providing child is under 19 and has no surviving parent
- Unmarried child of retiree and under 19 with no surviving parent.

Please note: Surviving spouse coverage does not extend to domestic partners.

Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF:

- Spouse or domestic partner (DP)
- Unmarried children under age 19 or full-time student under the age of 24
- Unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19
- Child covered by terms of a qualified medical child support order (QMCSO).

Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the EUTF, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

Special Eligibility Requirements

Student

A child over age 19 and under 24 is eligible if attending a full-time accredited college, university or technical school. This includes children who are away at school and dependent upon you for support.

Domestic Partner

Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intend to remain in a domestic partnership with each other indefinitely
2. Have a common residence and intend to reside together indefinitely
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care
4. Neither are married or a member of another domestic partnership
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii
6. Both at least 18 years of age and mentally competent to contract
7. Consent to the domestic partnership not been obtained by force, duress or fraud
8. Both sign and file a declaration of domestic partnership (affidavit) to the EUTF

If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on your W-2. This income is subject to normal payroll taxes. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available on the EUTF website, www.eutf.hawaii.gov) to the EUTF. Please refer to the website for detailed information and instructions.

Enrollment

During Open Enrollment 2005, you only need to return your pre-completed OE-2 form if you are making changes. Subsequently, those who become eligible must complete an EUTF Enrollment Form for Retirees (OE-2).

If you do not enroll all eligible members of your family within 30 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year, usually two to three months prior to July 1. Coverage dates for all plans begin July 1 and end June 30 of the following year.

ID Cards

After you enroll for the first time, you will receive identification cards from the plans as follows:

- HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- Kaiser issues an ID card for each enrolled member of a family only upon initial enrollment.
- VSP, Mutual Benefit Association of Hawaii (provider of ChiroPlan) and Royal State do not issue ID cards.

Dual Enrollment Is Not Allowed

Dual enrollment is not allowed under the EUTF rules. If both you and your spouse are employees of the State or a county, one of you may only enroll in a Family plan, or if no other dependents are involved, both enroll in a Self plan. If your spouse has coverage outside of the EUTF that provides a family coverage, this rule does not preclude you from also enrolling in a family coverage plan to cover your spouse. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Change of Coverage

To change your coverage, you should contact the EUTF and complete an EC-2. You are eligible to change your coverage outside the Open Enrollment period under the following circumstances:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child.
3. You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns 19 or 24 for student).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

Effective Dates of Coverage

The effective date of coverage is the later of:

- The date of the event that makes you eligible for enrollment when a properly completed enrollment application is filed within 30 days of the event; or
- The first day of the month following the date you file a properly completed enrollment application.

Your enrolled eligible dependents' coverage is effective the same date as yours.

Coverage changes involving the addition of dependents are effective retroactive to the date of the event or the date the EUTF receives proper notification, depending on the event and providing that the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24, in the case of full-time students, and do not require the completion of an application to delete coverage.

End of Coverage

Coverage for you and your dependents will end if:

1. You voluntarily terminate coverage
2. You do not make required premium payments (retirees enrolled in a Kaiser multi-site plan that requires contributions);
3. You die except for certain exceptions;
4. Your employer ceases to participate in the EUTF; or
5. The EUTF is discontinued.

Coverage for your dependents will end if your coverage ceases for any of the reasons listed above or:

1. Your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 19, or 24 if a student unless the dependent child qualifies for continuance of coverage due to disability);
2. Your enrolled dependent enters the uniformed services.

Effective Date of Termination

In general, coverage ends on the first day of the pay period after the event giving rise to the end of coverage. There may be certain instances in which the effective date is different such as a divorce, when coverage ends on the date the EUTF receives notification of the divorce. You may obtain additional information from your DPO or by referring to the EUTF Administrative Rules that are posted on the EUTF website, www.eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria outlined on the previous pages and detailed in the Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified of the rejection of any enrollment application.

Medicare Part B

Act 136, SLH 1999 requires all retirees and their spouses who become eligible for federal Medicare Part B medical plan coverage after June 24, 1999 to enroll in that federal benefit plan to be eligible for health benefits under the retiree plan. Retiree spouses who are actively working but covered by the retiree plan are also required to enroll in Medicare Part B to be eligible for coverage.

Please follow these guidelines to continue your EUTF retiree benefits:

If you are under age 65 and receiving Social Security retirement benefits, Social Security Administration will enroll you in the federal Medicare Part A hospital insurance plan and Part B medical insurance plan on your birthday month. Do not decline Medicare Part B. You will normally receive a red-white-blue Medicare card prior to your 65th birthday.

When your receive your Medicare Part B care, complete an enrollment form (EC-2) and send signed copy to the EUTF with a photocopy of your red-white-blue Medicare card. You may call the EUTF for the form or access our website to download the EC-2 form.

The EUTF is authorized to reimburse you for Medicare Part B premiums only if you submit a copy of the Medicare Part B card to the EUTF. The reimbursement will begin the date you enrolled with Medicare or when the EUTF receives a copy of your card, WHICHEVER IS LATER.

If you are over age 65 and not enrolled to receive Social Security retirement benefits, please call 800-772-1213 to enroll in the federal Medicare Part B medical insurance program immediately. Upon receipt of your red-white-blue Medicare card, make a photocopy and send it to the EUTF.

Upon receipt of your Medicare card, the EUTF will reimburse you the authorized amount for your Medicare Part B medical insurance plan premiums, including your eligible spouse's premiums, on a quarterly basis. The authorized amount is based on the Medicare Part B premium published each November by Medicare. Your reimbursements are sent to arrive at your address during the first week after the end of each quarter.

The Medicare Part B reimbursement is not available for domestic partners.

Chapter 87A, Hawaii Revised Statutes, paragraph 87A-23 establishes the requirement for all employee-beneficiaries or dependent-beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the benefits plans offered by EUTF. The EUTF Administrative Rules, paragraph 5.03(a) establishes the effective date of coverage for Medicare Part B. For more information, you may contact the EUTF.

Administrative Appeals

A person aggrieved by one of the following decisions by the EUTF may appeal to the board for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within thirty days of the date of the decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;

2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including, the date of the decision;
4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The board shall grant or deny the appeal within a reasonable amount of time. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the EUTF's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

INSTRUCTIONS FOR COMPLETING EC-2 FORM

A. Print or type **clearly**. if form is unreadable it may be sent back to you.
B. **Please submit form to Hawaii Employer Union Health Benefits Trust Fund (EUTF)**
C. Sections:
   1. Event - Enter a qualified event

New Retiree	Delete Dependent	Medicare Part B
Marriage	Add Dependent	Other
Medicare Eligible	Divorce	
Surviving Spouse / Child	Death of Spouse	
Open Enrollment	Change Address	

   2. Event Date – Enter the date of the Event
   3. Enter Last Name, First Name, M.I., Social Security No., Date of Birth, Gender, Marital Status, Daytime/Evening Phone Number, Mailing Address, City, State and Zip Code in the appropriate spaces.
   4. Enter Social Security Number of Spouse or Domestic Partner and check appropriate box.
   5. Check add box to add dependent, check delete box to delete dependent.
   6. Enter Dependent(s) Name, SSN and Birth date.
      If listing more than 3 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
   7. Use the following codes for Relationship column:
      SP = Spouse **CH** = Child **DC** = Disabled Child``
      DP = Domestic Partner` **DPC** = Domestic Partner Child`
      For Relationship codes with ` or ``, please see below for other EUTF forms.
   8. Gender – circle either M or F.
   9. **Plan Selections** (See Reference Guide for Plan Coverage Details).
      Check the appropriate boxes to select your medical, dental and vision plans.
   10. **Comments**
   11. **Certification**
      Signature of Retiree certifies that the information provided in this application is true and complete.
      Retiree agrees to abide by the terms and conditions of the benefit plans selected.
      Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student.
      Please enter date of Retiree's signature.

Other EUTF forms to include with EC-2 (if applicable):

`Domestic Partnership Declaration or Termination
`Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
``D-1 (5/2003) for enrolling disabled child
Proof of Medicare Part B enrollment
AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)

Reference materials

Reference Guide for Retirees
Retirement Health Insurance Benefits Information Booklet (New Retirees only)

Keep a copy for your reference

Form EC-2 Revised July 2004

EC-2

Hawaii Employer-Union Health Benefits Trust Fund

ENROLLMENT FORM FOR RETIREES

Customer Service Phone: 586-7390 or toll free 1-800-295-0089

1. Event:

2. Event Date: (MM/DD/YY)

See Instructions on reverse side BEFORE completing this form.

3a. Retiree's Last Name, First, M.I	3b. Social Security Number:	
3c. Mailing Address:	3d. Birth Date: (MM/DD/YY)	3e. Marital Status: ❑ Married ❑ Single
3f. City: 3g. State: 3h. Zip Code:	3i. Phone Number	3j. Gender: ❑ Male ❑ Female

4. Social Security Number of Spouse or Domestic Partner / /

❑ State or County - Employee or Retiree

❑ Other – Private, Federal ,etc

5a. Add	5b. Delete	6a. Dependents' First Name, M.I., Last Name	6b. Social Security Number	6c. Birthdate MM/DD/YY)	7. Relationship	8. Gender
❑	❑					M F
❑	❑					M F
❑	❑					M F

9. Plan Selections, Changes or Cancellations

a. Make your selection by checking the box(es) for the appropriate benefit plans below.
b. Select either Self, Family or Cancel/Waive coverage.
c. Choose only one box in each plan section.

Plan Section	Carrier Selection	Self	Family	Cancel / Waive
Medical / Drug	HMSA PPO Medical and Drug	❑	❑	❑
	Kaiser Medical and Drug	❑	❑	
Dental	HDS Dental	❑	❑	❑
Vision	VSP Vision	❑	❑	❑
AETNA Life Insurance Plan (Retiree Only)		❑		❑

10. Comments _____

11. Certification (see instructions on back of this form)

Retiree's Signature: _____ **Date:** _____

For EUTF Use Only (DO NOT WRITE BELOW HERE):

12. Dept ID#	13. Code	14. Retirement Date / /	15. BU
16. RET Elig for Reimbursement on		17. RET Elig for Reimbursement on	
18. Survivor of		19. RET SSN	20

Fax to 808-586-2161 OR **Mail** to EUTF, P.O. Box 2121, Honolulu, HI 96805-2121 OR **Deliver** to 201 Merchant Street, Suite 1520.

EC-2

Form EC-2 Revised Mar2004

Medical - PPO Plan

HMSA

This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained from HMSA or from the EUTF website, www.eutf.hawaii.gov, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits, the latter will take precedence.

If you have any questions, please contact HMSA at any of the following locations:

Oahu 818 Keeaumoku Street
Honolulu, HI 96814
Phone: (808) 948-6499

Hawaii 670 Ponahawai Street, Suite 121
Hilo, Hawaii 96720
Phone: (808) 935-5441

75-1029 Henry St., Suite 301
Kailua-Kona, Hawaii 96740
Phone: (808) 329-5291

Kauai 4366 Kukui Grove Street, Suite 103
Lihue, HI 96766
Phone: (808) 245-3393

Maui 33 Lono Avenue, Suite 350
Kahului, HI 96732
Phone: (808) 871-6295

All member copayments shown are based on the eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. Services received from a nonparticipating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

Lifetime Maximum	$2,000,000
Maximum Annual Co-payment	$2,500 per person/$7,500 per family
Annual Deductible	$100 per person/$300 per family

	Member Co-payment	
	Participating	**Nonparticipating**
Physician Services	Copayment amount after annual deductible met where noted (*)	
Physician Visits, Well Woman Exam (one per year), Maternity Care	10% of Eligible Charges	30% of Eligible Charges*
Immunizations —Standard	None	30% of Eligible Charges
Immunizations—Well Child Care	None	None*
Surgery (Cutting), Anesthesia	None	None
Surgery (Non-Cutting)	10% of Eligible Charges	30% of Eligible Charges*
Testing, Laboratory and Radiology—Outpatient [1]	20% of Eligible Charges	30% of Eligible Charges*
Allergy Testing and Allergy Treatment Materials	20% of eligible Charges*	30% of Eligible Charges*
Diagnostic Testing and Radiology, Tuberculin Skin Test, Pap Smear, PSA, RSVP Screenings	20% of Eligible Charges	30% of Eligible Charges*
Screening Mammography	20% of Eligible Charges	30% of eligible Charges

Note: [1] HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.

HMSA

	Member Co-payment	
	Participating	**Nonparticipating**
Organ and Tissue Transplants		
Corneal, Kidney, Small Bowel and Small Bowel/Liver Transplants	10% of Eligible Charges	30% of eligible Charges*
Bone Marrow, heath, hearth/Lung, Liver, Lung, Kidney/Pancreas transplants or Transplant Evaluation [2]	None	Not covered
Note: [2] HMSA has contracted with certain providers for specific transplant services. You must receive services from a contracted provider for these benefits to apply.		
Chemotherapy and Radiation Therapy—Outpatient		
Chemotherapy	20% of Eligible Charges*	30% of Eligible Charges*
Radiation Therapy	20% of Eligible Charges	30% of Eligible Charges*
Hospital and Facility Services		
Emergency Room	10% of Eligible Charges	10% of Eligible Charges
Hospital Room, Skilled Nursing Facility, Ambulatory Surgical Center	10% of Eligible Charges	30% of Eligible Charges*
Behavioral Health - Mental Health [3] and Substance Abuse		
Inpatient Hospital/Facility Services, Physician Services	Regular Plan benefits	Regular Plan Benefits
Psychological Testing – Outpatient	10% of Eligible Charges	30% of Eligible Charges*
Note: [3] Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year. Limitations do not apply to serious mental illnesses in accord with Hawaii law. There is no limit for substance abuse services.		
Special Benefits for Homebound, Termina, or Long-term Care		
Home Health Care	None	30% of Eligible Charges
Hospice Services	None	Not Covered
Other Medical Services and Supplies		
Ambulance, Appliances/Equipment, Blood, Dialysis, Injections, Physical Therapy, Occupational Threapy, or Speech therapy	20% of Eligible Charges*	30% of eligible Charges*
Medical Foods	20% of Eligible Charges	20% of Eligible Charges
Special Benefits for Health Assessment, Health Education, and Disease Management		
HealthPass , Disease Management Programs	None	Not Covered

HMSA

Blue Cross Blue Shield of Hawaii

BENEFITS	MEMBER PAYS	
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Generic	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Preferred Brand Name	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Brand Name	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Insulin		
Preferred Insulin	$5 copayment	$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Insulin	$15 copayment	$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	$15 copayment	$15 copayment
Oral Contraceptives		
Preferred Oral Contraceptives	$5 copayment	$8 copayment
Other Oral Contraceptives (including generic contraceptives)	$30 copayment	$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diaphragms		
Preferred Diaphragms	$10 copayment	$12 copayment
Other Diaphragms	$20 copayment	$20 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
BENEFITS	**MEMBER PAYS**	
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	**HMSA Vendor**	**Non-HMSA Vendor**
Generic	$10 copayment	Not a benefit
Preferred Brand Name	$35 copayment	Not a benefit
Other Brand Name	$60 copayment	Not a benefit
Insulin		
Preferred Insulin	$10 copayment	Not a benefit
Other Insulin	$35 copayment	Not a benefit
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	Not a benefit
Other Diabetic Supplies	$35 copayment	Not a benefit

Medical - HMO Plan

KAISER PERMANENTE

There are two HMO plans available for retirees: Kaiser Permanente Group Plan for retirees under age 65 and Kaiser Permanente Senior Advantage for retirees over age 65 living on Oahu, Maui and Hawaii (except zip codes 96718, 96772 and 96777). Benefit summaries for both plans are included in this booklet.

Retirees living on the Mainland who wish to enroll in Kaiser Senior Advantage need to contact and complete enrollment forms with the local Kaiser plan before being enrolled in Kaiser multi-site in the EUTF system.

Kaiser Permanente Group Plan

This plan is only available to retirees under the age of 65. This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician. For specific questions about coverage, please call the Customer Service Center at (808) 432-5955 (Oahu) or 1-(800) 966-5955 (Neighbor Islands). You may also obtain information from the Kaiser website, www.kaiserpermanente.org.

Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

	Benefits	You pay
	Deductible	None
	Lifetime Maximum	None
	Annual supplemental charges maximum per calendar year	$1,500 per member $4,500 per family unit (3 or more members)
Preventive services	**Well-baby visits**	$12 office visit copayment per visit
	Immunizations	No charge for most immunizations (some have a 50% copayment)
	Physicals, routine and school	$12 office visit copayment per visit
Outpatient services	**Office visits** doctors' & other health professionals'	$12 office visit copayment per visit
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Outpatient surgery and procedures	$12 office visit copayment per visit
	Routine obstetrical care (prenatal, delivery, and mother's care in the hospital following delivery)	No charge upon confirmation of pregnancy
	Abortions, elective or medically indicated	$12 per visit (elective abortions limited to two per lifetime)
	Administered drugs	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit charge for the visit.

KAISER PERMANENTE

	Benefits	You pay
Outpatient services, continued	**FDA-Approved contraceptive drugs and services**	50% of applicable charges
Inpatient services	**Hospital** (room and board)	No charge
	Doctors' medical and surgical services	No charge
	Anesthesia services	No charge
	Lab, X-ray, and diagnostic testing	No charge
	Administered drugs	No charge for most drugs administered during a covered hospital stay
	Skilled nursing care	No charge up to 100 days per benefit period
Mental health services (B rider)	**Outpatient up to 24 visits/calendar year**	$12 office visit copayment per visit
	Inpatient up to 30 days/calendar year	No charge
Chemical dependency services	**Outpatient**	$12 office visit copayment per visit
	Inpatient	No charge
Emergency services (for initial treatment only) & ambulance services	**At a facility <u>within</u> the Hawaii service area**	$25 per visit, plus other applicable plan charges
	At a facility <u>outside</u> the Hawaii service area	20% of R & C*, plus other applicable plan charges
	Ambulance services	20% of R & C*, plus other applicable plan charges
Additional Services	**Prescription drugs – drug 10**	$10 for each prescription not exceeding a 30 consecutive day supply (excludes contraceptive drugs and devices)
	Prescription drug mail order incentive	Members may purchase mail order refills for most maintenance drugs for a 90 consecutive day supply upon payment of two drug copayments. The mail order program does not apply to certain drugs and mailing is limited to addresses inside the State of Hawaii.
Internal/ External prosthesis	**Durable medical equipment**	20% of applicable charges

You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.

Enrollment in Senior Advantage is required for all State and County Medicare-eligible retirees residing on the islands of Oahu, Maui and Hawaii (except for zip codes 96718, 96772, 96777). For more information about Senior Advantage, please contact Kaiser Permanente

KAISER PERMANENTE

Customer Service at (808) 432-5955 or 1-800-966-5955 (neighbor islands). You may also obtain information from the Kaiser website, www.kaiserpermanente.org.

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control. Senior Advantage members should refer to their Kaiser Permanente Senior Advantage Evidence of Coverage for a description of their benefits.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician.

If you live outside the Hawaii service area, membership in an out-of-state region may be available to you. Members enrolled outside the Hawaii service area may not have the same benefits described in this booklet and may have to contribute to the premium if the region's premium is higher than the amount allowed by Act 88 for the State's contribution. If you are already enrolled in an out-of-state Kaiser Permanente Plan you will receive information about your options in a separate mailing. If you are currently not enrolled in an out-of-state Kaiser Permanente Plan but would like information, please contact the EUTF Customer Service Hotline at 808-586-7390 or email us at eutf@hawaii.gov.

	Benefits	You Pay
Outpatient services	**Doctors' and other health practitioners' office visits**	$12 office visit copayment per visit
	Preventive care Health evaluations for adults Physical examinations for children, and well-baby care	$12 office visit copayment per visit
	Immunizations **generally available in the Hawaii service area:**	
	Immunizations developed and in general use for specific diseases on March 1, 1994	No charge
	Immunizations developed or in general use for specific diseases after March 1, 1994	50% of applicable charges
	- Exception: Immunizations covered by Medicare	20% of applicable charges
	- Exception: Immunizations in keeping with "prevailing medical standards: (as defined by State law) for children 5 years of age or under	No charge
	Unexpected mass immunizations	50% of applicable charges
	Injectable travel immunizations	50% of applicable charges plus $10 office visit copayment
	Oral travel immunizations	$10 per prescription
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Short-term physical, occupational and speech therapy	$12 office visit copayment per visit
	Dialysis Kaiser Permanente physician and facility services for dialysis Equipment, training and medical supplies for home dialysis	 No charge No charge
	Outpatient surgery and procedures	$12 copayment per visit
	Materials for dressings and casts as covered by Medicare	No charge after $10 copayment
Outpatient services continued	**Take-home supplies** covered by Medicare	20% of applicable charges
	All other take home supplies	Not covered

KAISER PERMANENTE

	Benefits	You Pay
	Transplants, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, intestinal and multi-visceral	No charge for the procedure (drugs according to member's drug coverage)
Prescribed drugs that require skilled administration	**Prescribed drugs that require skilled administration by medical personnel** (e.g., cannot be self-administered) Prescribed by a Kaiser Permanente licensed prescriber and on the Health Plan formulary, and used in accordance with formulary criteria, guidelines or restrictions	No charge after $12 office visit copayment
	Chemotherapy drugs for the treatment of cancer Exclusions: Drugs that are necessary or associated with services that are excluded or not covered	No charge after $12 office visit copayment
Prenatal care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	**Prenatal care** (prenatal care, delivery, and mother's care in the hospital following delivery)	No charge after confirmation of pregnancy
	Interrupted pregnancy and family planning services	$12 office visit copayment per visit
	Involuntary infertility services (not including lab, prescribed imaging or drugs)	$12 office visit copayment per visit
	Artificial insemination	Not covered
	In vitro fertilization	Not covered
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician. **Hospice care**. Covered under original Medicare and may have copayment.	No charge
Skilled nursing care	Up to **100 days of prescribed skilled nursing care services in a Medicare-approved facility** (such as a hospital or skilled nursing facility) **per benefit period.** **Exclusions:** Personal comfort items, such as telephone, television and take-home medical supplies.	No charge
Emergency services	**Note:** Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.	$25 worldwide
Out-of-area urgent care services	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only and while temporarily outside the Hawaii service area)	$25 worldwide
Ambulance services	Ambulance Services are those services in which: use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and is for the purpose of transporting the member to receive medically necessary acute care. In addition, if air ambulance, the member's condition must require the services of an air ambulance for safe transport.	20% of all reasonable and customary charges
Blood (inpatient or outpatient)	Regardless of replacement, units and processing of units of whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician.	No Charge
	Donor directed units	Not covered

KAISER PERMANENTE

	Benefits	You Pay
Mental health services	Unlimited visits per calendar year for serious mental illness as defined by Hawaii law.	$12 office visit copayment per visit
	Other mental illnesses – visits 1 through 20 per calendar year	20% of applicable charges
	Other mental illnesses – visits 21+ per calendar year	50% of applicable charges
	Inpatient: first 190 lifetime days and 190+ days for serious mental illness	No charge
	Up to 30 days per calendar year for other mental illness after 190 lifetime days have been used.	20% of applicable charges
Chemical dependency services	Outpatient visits	$12 office visit copayment per visit
	Residential chemical dependency services up to 60 days per calendar year	20% of applicable charges
Internal prosthetics, devices, and aids	Surgically-implanted internal prosthetics (such as pacemakers and hip joints), and surgically-implanted devices and aids (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods) which are medically indicated, prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan	No charge
	Internal prosthetics not surgically implanted	20% of applicable charges
	Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	20% of applicable charges
External prosthetic devices and braces	**External prosthetic devices and braces**, when prescribed by a Kaiser Permanente physician, and obtained from sources designated by Health Plan	20% of applicable charges
	Fitting and adjustment of these devices, including repairs and replacements other than those due to misuse or loss	20% of applicable charges
Durable medical equipment	Medically necessary and appropriate **durable medical equipment for use in the home**, when prescribed by a Kaiser Permanente physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan	20% of applicable charges
	Oxygen for use in conjunction with prescribed durable medical equipment	20% of applicable charges
	Repair, replacement and adjustment of durable medical equipment, other than those due to misuse or loss	20% of applicable charges
Diabetes equipment	**Glucose meters and external insulin pumps** (and the supplies necessary to operate them) when Health Plan criteria are met.	20% of applicable charges

KAISER PERMANENTE

	Benefits	You Pay
Drug	**For each prescription, when the quantity does not exceed:** a 30–consecutive-day supply of a prescribed drug, or one dose of a self-administered injectable drug, or one cycle of an oral contraceptive drug, or an amount as determined by the Formulary.	$10 per prescription
	Insulin and certain diabetes supplies	$10 per prescription
	Oral contraceptive drugs	50% of applicable charges
	Diaphragms and cervical caps	50% of applicable charges
	Other contraceptive drugs and devices	50% of applicable charges
Mail order	Mail order prescription forms may be obtained at any Kaiser Permanente pharmacy, or call the Kaiser Permanente mail order pharmacy at 432-5510, Monday - Friday, 8:30 A.M. to 5:00 P.M. You may purchase a 3 month's supply of maintenance medications at 2 co-payment amounts through Kaiser Permanente's mail order prescription service, restricted to ZIP codes in the Kaiser Permanente service area. Please mail your refill order before you are down to your last 10 days supply. Allow one week to receive your medication for refillable orders. The mail order program does not apply to the delivery of certain pharmaceuticals (i.e., controlled substances as determined by State and/or Federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Pharmacy and Therapeutics Committee)	
Supplemental charges maximum	Your out-of-pocket expenses for covered Basic Health Services are capped each calendar year by a Supplemental Charges Maximum.	$1,500 per member, $4,500 per family unit (3 or more members)

You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.

HDS Dental Plan

HDS Hawaii Dental Service
DELTA DENTAL

Summarized below are the dental benefits provided through Hawaii Dental Service (HDS). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the HDS Customer Service Department at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248. You may also obtain information from the HDS website, www.deltadentalhi.org.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	$1,000/ person
Diagnostic	
Examinations (twice per calendar year)	100%
Bitewing x-rays (twice per calendar year)	100%
Other x-rays (full mouth x-rays limited to once every three years)	100%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	100%
Stannous fluoride (once per calendar year through age 17)	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	100%
Restorative	
Amalgam (silver-colored) fillings	60%
Composite (white-colored) fillings, limited to anterior (front) teeth	60%
Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Endodontics	
Pulpal Therapy	60%
Root canal	60%
Periodontics	
Periodontal scaling and root planning – once every two years	60%
Gingivectomy, flap curettage and osseous surgery - - once every three years	60%
Periodontal maintenance – twice per calendar year	60%
Prosthodontics	
Fixed Bridges (once every 5 years; ages 16 and older)	60%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	60%
Repairs and adjustments	60%
Relines and rebase	60%
Implants (covered as alternate benefit) when one tooth is missing between two natural teeth	60%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	60%
Adjunctive General Services	
Consultations by Specialist not performing services	60%
Office visits (injury related)	60%
Sedation General and IV – Oral Surgery Only	60%
Palliative (Emergency) treatment (for relief of pain but not to cure)	100%

Benefit Exclusions

Your HDS plan does not cover the following services:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Vertical dimension, occlusal adjustment, equilibration, periodontal splinting, restoration of tooth structure lost from wearing away, restoration for tooth malalignment, jaw movement recordings and treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to subscriber by a dentist
- All other services not specified in the Schedule of Benefits, which is available from your employer.

Multi-state Coverage

If you or your family reside or travel outside Hawaii and need dental care, your HDS plan will provide you coverage. HDS is a member of Delta Dental Plans Association, the largest dental benefits provider in the nation. So if your job takes you out of state or your son or daughter attends school on the Mainland, the charges of participating dentists would be capped by their respective state's eligible fees for covered services.

While on the Mainland, you can maximize your benefits by selecting a dentist who participates with Delta Dental. To obtain a list of participating Delta dentists in that zip code, visit the Delta Dental web site at www.deltadental.com and use the 'Dentist Search' capability. Or you may call our Customer Service Department toll-free at (800) 232-2533 ext. 248 and we will send you a list of participating dentists in your area.

Visiting a Participating Delta Dentist

If the dentist you have selected is a participating HDS or Delta (on the Mainland) dentist, he will submit the claim directly to HDS for you. Be sure he obtains HDS's mailing address from the back of your member identification card. HDS's payment will be based upon the participating dentist's eligible fees in his state. (HDS uses the National Provider File to obtain these fees.) Your share will be limited to the difference between the participating dentist's eligible fee and HDS's payment amount.

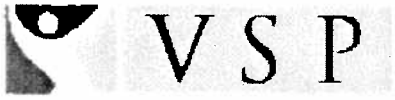
Visiting a Non-Participating Dentist

When you visit a non-participating dentist, in most cases you will need to pay in full at the time of service. On your first visit to a non-participating dentist, advise the dentist that you have an HDS dental plan and present your HDS member identification card. Your dentist will render services and may send you the completed claim form (universal ADA claim form) to file with HDS. Mail the completed claim form to the following address for processing:

HDS - Dental Claims
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

HDS will pay for services rendered up to your benefits coverage amount. Please be aware that your non-participating dentist's fees may be higher than a participating dentist's fees, and the fees used to calculate your benefit are lower than participating dentists' eligible fees. You are responsible for the difference between your non-participating dentist's fees and HDS's payment amount.

VSP Vision Plan



Summarized below are the vision benefits provided through Vision Service Plan (VSP). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or call VSP's Customer Service Department—Hawaii Office: (808) 532-1600, or toll-free from the neighbor islands at 800-522-5162; Customer Service call Center (mainland U.S.) at 800-877-7195. You may also obtain information from the VSP website, www.vsp.com.

	VSP Doctor	*Out-of-Network Reimbursement*
Eye Exam	$10 Co-payment	After Co-pay:
Every 12 Months*	No Charge	Up to $40
Materials (lenses and/or frame)	$25 Co-payment	After Co-pay:
Every 12 Months*		
Single Vision	No Charge[1]	Up to $40
Bifocals	No Charge[1]	Up to $60
Trifocals	No Charge[1]	Up to $60
UV Coating	No Charge	No Additional Benefit
Frame		
Every 24 Months*	Covered Up to $105 Allowance[2]	Up to $40
Contacts (in lieu of glasses)		
Every 12 Months*	Covered Up to $100 Allowance[3]	Up to $100

* Based on your last date of service.

1 Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing.

2 If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket cost for frames.

3 Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Life Insurance Benefits

Aetna

Life insurance benefits are underwritten by Aetna Life Insurance Company. This is a summary of the plan benefits. For complete information and provisions, please refer to your certificate or contact Aetna or the EUTF.

Customer Service: 1-866-227-9954 (toll-free)
Claim Office:
Aetna Inc.
Life Service Center
151 Farmington Avenue – RE52
Hartford, CT 06156-3007
Fax Number for Claim Submission: 1-800-238-6239
Website: www.aetna.com

In the event of your death, the life insurance company will pay your beneficiary $1,900. The death benefit amount will be reduced by any amount previously paid under the Accelerated Death Benefit provision, described below.

Designation of Beneficiary Form

Please download the form from the EUTF website at www.eutf.hawaii.gov or call the EUTF to have it sent to you.

Classification Change Date

Any change in your life insurance classification will become effective on the date of your 65th, 70th, 75th, and 80th birthday, or your retirement from active employment.

Accelerated Death Benefit

If, while covered under this life insurance plan you become terminally ill, you may request that the life insurance company pay an Accelerated Death Benefit. Your physician must certify that you suffer from a terminal illness and have a life expectancy of 12 months or less. Upon approval of your request, the insurance company will pay up to 75% of your life insurance benefits, with a minimum payment of $5,000. A nominal amount of interest is charged for the accelerated payment, as defined in your life insurance certificate. The Accelerated Death Benefit payment will be reduced by an interest discount to account for the early payment.

Life Insurance Conversion

If your life insurance ceases because of termination of employment or is reduced due to age, you may convert to an individual policy. You must apply within 31 days of the following events:

- Your insurance ends because you are no longer eligible, you may convert to an amount of life insurance equal to the amount of insurance you had prior to your termination.
- When you reach age 65, 70, 75, and 80 as an active employee and at retirement, you may convert to the amount being reduced.

If you die within the 31-day conversion period, and before the individual policy goes into effect, the amount payable is the maximum amount you could have converted. This amount applies even if you had not applied for or paid the first premium on the individual policy.

Important Notices

Many federal and state laws guide the administration of all health benefits insurance plans. While official insurance contracts actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and your official insurance documents, the official insurance documents will prevail.

If you have any questions about this section, please call the Hawaii Employer-Union Health Benefits Trust Fund (the EUTF). See page 34

Women's Health & Cancer Rights Act

Your health insurance plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductibles, copayments, and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call your insurance carrier or the EUTF.

Newborns' & Mothers' Health Protection Act

Generally, group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery, or
- Less than 96 hours following a caesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

Your health insurance plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under the health insurance plan,
- Name and last known address of each child to be covered under the health insurance plan,
- Type of coverage to be provided to each child, and
- Period of time coverage will be provided.

Send QMCSOs to the EUTF, which is your Plan Administrator. Upon receipt, the EUTF will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan.

National Medical Support Notices

The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs). These Notices are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order. Upon receipt of the NMSN, the Employer will, within 40 business days, return the Notice to the state agency if the specified coverage is not available for one of the reasons set forth on the Notice, or forward the Notice to the EUTF, the Plan Administrator, if the specified coverage is available.

If the Employer forwards the Notice to the EUTF, the EUTF will, within 40 business days, return the Notice to the state agency and/or the parties concerned to inform them whether the Notice constitutes a QMCSO.

If the Notice qualifies, the EUTF will notify the state agency either that the child(ren) is/are currently enrolled or will be enrolled in the coverage available under the EUTF.

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state

agency of the coverage options from which you may elect coverage. In this event, the EUTF will also notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

If the Notice is not qualified, then within 40 business days, the EUTF will notify the state agency and the parties involved, the specific reason(s) why the Notice failed to qualify. The EUTF may also provide additional notifications as provided for in the NMSN's instructions.

Continuation of Group Health Coverage Under COBRA: Initial Notice

A federal law, commonly known as "COBRA," requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event" (listed below).

The section serves as your initial notice of your rights and obligations under COBRA. It is subject to change without warning, as interpretations or changes in the law do occur. Please read this notice carefully, share it with your family, and keep it in your file.

Qualifying Events

Employees

If you are an employee covered under a group health plan, you (and your covered dependents) may elect COBRA coverage if you lose your group health coverage due to either of these "qualifying events":

- Termination of your employment (for reasons other than gross misconduct), or
- Reduction in your work hours causing you to be ineligible for health benefits insurance.

Covered Spouses

If you are the covered spouse of an employee enrolled in a group health plan, you may elect COBRA coverage if you lose group health coverage due to any of these "qualifying events":

- Termination of your spouse's employment (for reasons other than gross misconduct), or reduction in your spouse's work hours causing him or her to be ineligible for Plan benefits,
- Death of your spouse,
- Divorce or legal separation from your spouse, or
- Employee-beneficiary becomes entitled to Medicare benefits.

Covered Children

Dependent children who are covered under a group health plan have the right to elect COBRA coverage if they lose coverage under the Plan due to any of these "qualifying events":

- The employee-parent's employment stops (for reasons other than gross misconduct), or work hours are reduced resulting in ineligibility for Plan benefits,
- Death of the employee-parent,
- Parents' divorce or legal separation,
- Employee-parent becomes entitled to Medicare benefits, or
- Dependent child ceases to be a "dependent child" under the health insurance plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment or the death of the employee, your employer must notify the Plan Administrator of the Qualifying Event. The employee will not need to notify the EUTF of the occurrence of any of these three Qualifying Events.

You Must Give Notice of Some Qualifying Events

For the other initial Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the Plan Administrator with notice of the Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date of the loss of coverage under the Plan.

You must provide this notice in writing by appropriately completing the attached "Notice of a COBRA-Related Event." For detailed instructions on completing this Notice, the documentation required to accompany the Notice and the procedures for submitting the Notice, see the EUTF's website or contact the Plan Administrator. If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

Cost of Coverage

Insurance carriers providing coverage for the EUTF beneficiaries will administer the billing and collection of COBRA premiums.

You will be charged the full premium under the group health plan for COBRA coverage, plus a 2% administrative charge. If you are disabled and you extend your coverage for more than 18 months, you will have to pay the full cost of coverage plus another 50% of the premium for months 19 through 29.

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months.

The COBRA continuation coverage periods described above are maximum coverage periods. COBRA coverage can end before the maximum coverage period described in this Notice for several reasons. For more information refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

There are three ways in which this 18-month period of COBRA continuation coverage resulting from a reduction in hours or employment or termination of employment can be extended.

Disability extension of 18-month period of continuation coverage

If a Qualified Beneficiary in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum COBRA coverage period of 29 months. For more information regarding this disability extension of the COBRA coverage period, the timeframe and procedures for providing the notice of disability and the cost of COBRA coverage during any disability extension period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving 18 (or 29) months of COBRA continuation coverage resulting from the covered employee's termination of employment or reduction in hours of employment (or during the disability extension period following either of these Qualifying Events), the spouse and dependent children in your family who are receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for up to a maximum of 36 months of COBRA continuation coverage, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (This extension in the COBRA coverage period is not available under the Plan when a covered employee becomes entitled to benefits under Medicare.) For more information regarding second Qualifying Events and the timeframe and procedures for providing the notice of a second Qualifying Event, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Medicare extension for a spouse and dependent children

If an employee loses coverage under the Plan due to a termination of employment or reduction of hours of employment that occurs within 18 months after the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both), then the maximum coverage period for the spouse and dependent children (but not the employee) will be up to 36 months from the date the employee became entitled to Medicare benefits. However in this situation, the covered employee's maximum coverage period will be 18 months. For more information regarding this Medicare extension of the COBRA coverage period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Children Bom To or Placed for Adoption with the Covered Employee during a Period of COBRA Continuation Coverage

A child bom to or adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the covered employee is a Qualified Beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. For more information regarding a newly acquired dependent

child's COBRA, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Alternate Recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights under COBRA as a eligible dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent under the eligibility requirements of the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you must notify the Plan Administrator of any changes in the addresses of family members by submitting a fully completed Enrollment Change form (EC-1) to the Plan Administrator. The EC-1 form is available from the Plan Administrator. You should also keep a copy, for your records, of any notices or forms you send to the Plan Administrator.

Plan Contact Information

For more information about COBRA, you may contact the Plan Administrator at the following address:

Hawaii Employer-Union Health Benefits Trust Fund

P.O. Box 2121

Honolulu, HI 96805-2121

Telephone: (808) 586-7390

Toll Free: (800) 295-0089

If you have questions regarding this Notice or your rights under COBRA, you may call the Plan Administrator at the telephone number shown above. You may also view the EUTF's "COBRA Notice" on the website at: www.eutf.hawaii.gov or find additional information about COBRA in the Reference Guide for Active Employees (effective July 1, 2005).

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

Effective date of this notice is March 1, 2005.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), govems all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information.

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you, and
- Follow the terms of the notice that is currently in effect.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the EUTF is allowed to use and disclose your medical information will fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

For EUTF Operations: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may

disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, Hawaii Dental Service, Vision Service Plans, ChiroPlan Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or not enrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied claim or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are

requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you — as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum

amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

Questions?

If you have any questions about this notice, please contact the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the EUTF Privacy Officer at the following address:

CONTACT INFORMATION

Mailing Address:	P.O. Box 2121 Honolulu HI 96805
Location Address:	201 Merchant Street, #1520 City Financial Tower Honolulu, Hawaii
Telephone Numbers	
Local number:	808-586-7390
Toll-Free number:	800-295-0089
Fax number:	808-586-2161
Email address;	eutf@hawaii.gov
Website address:	www.eutf.hawaii.gov

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